

PATIENTS' VIEWS OF NURSES' CLINICAL  
COMPETENCE: A GROUNDED THEORY  
APPROACH

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# ABSTRACT

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This thesis examines, from the viewpoint of the patient, what is meant by competent nursing and how, with this perspective in mind, patients would regard the prospect of assessing the competence of nurses. The study utilises a grounded theory approach. Twenty-seven patients were interviewed about their views of nursing care. Preliminary data collection was undertaken in general medical and surgical areas. A theoretical sampling strategy was developed to include more experienced patients in three specialty areas renal dialysis, cystic fibrosis and diabetes care. Data were analysed, in keeping with the grounded theory tradition, utilising the constant comparative method.

Patients described the process of becoming a patient and how they come to understand the complex social world of the hospital and the role of nurses within this. They identified the features of a good nursing encounter as being patient led, personal and individualised. Patients also identified their own responsibilities, specifically how to be a 'good' patient. Competence is defined narrowly by patients as technical care, but this technical care is assumed to be competent as safe guards are considered to be in place to protect patients. Some patients who are experienced in technical aspects of care were able to make judgements about technical care; the factors which facilitate and inhibit this are discussed. Patients support the exclusivity of professional judgement of technical competence.

Previous studies have highlighted the importance of the quality of the nursing encounter - the nurse/patient relationship, individualised patient care and empathy for example. This study specifically raises the issue that patients take technical competence for granted and highlights the important finding that when technical competence is assumed then these interpersonal factors become the most important indicator of the quality of nursing care. These personal and highly individual encounters between the patient and nurse and personality characteristics displayed such as caring and kindness, empathy and sense of vocation are difficult to measure or make objective judgements about. Although patients can discriminate between nurses who have these attributes and skills, being involved with the formal assessment of these attributes is considered a difficult prospect. The study findings emphasise that patient assessment of nursing competence is complex and implications for nurse education, policy and service provision are highlighted.



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# DECLARATION

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I hereby declare that this thesis has been composed by myself and that the research on which it reports is my own work.

Lynn Calman

November 2004

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# ACKNOWLEDGEMENTS

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I am deeply grateful to many people for their support throughout the composition of this thesis.

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# CHAPTER 1

## INTRODUCTION

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### **Introduction**

This PhD takes the form of a grounded theory study, which is based in the tradition of qualitative inquiry. The topic area of patients'<sup>1</sup> views of nursing competency has developed from the researcher's own interest in competence to practise in nursing, although this is an area that will be of relevance to all practice disciplines in health care. The word competence is used extensively in nursing education (Milligan, 1998) and competence is considered an essential component of being a nurse (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1999). Professional views about nursing competence are well documented in the literature (Eraut, 1998, Girot, 1993, While, 1991, Bradshaw, 1997 and 2000, Watkins, 2000); however, there is a paucity of empirical research that clarifies the nature of nurses' competence from the patient's perspective.

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<sup>1</sup> A note about terminology: During the course of this thesis the user of health services will be referred to as 'the patient'. There are many labels that are attached to the user of health services all with their own subtle differences in meaning (Iskander, 1997). The majority of literature reviewed in this paper uses 'patient' to identify those using services. The research was undertaken in an inpatient health care setting and it is the intention of the author to use 'patient' when referring to users of services.

## **Background**

The climate of health care is changing; the concept of patient/user involvement and empowerment is a key issue in the health services in the United Kingdom (UK) (Higgins 1994). There has been a spate of policy documents, both in the UK and internationally, that emphasise the importance of user involvement in health care (Poulton 1999). The National Health Service (NHS) Plan published in England in July 2000 (Department of Health 2000) clearly states that 'patients are the most important people in the health service'. 'Our National Health' published at the same time in Scotland (Scottish Executive 2000), indicates that patients should have more influence over their care and the way in which the NHS works. In 2003 a White Paper was published in Scotland that further emphasised patients key roles in the development of services and involvement in health care decision making (Scottish Executive 2003). However, patients often do not feel their views are recognised. Some attempts have been made to put into operation user views within nursing and nurse education and there is a growing body of literature supporting patient participation in nurse education (Forrest *et al* 2000; Rudman 1996). The pre-registration nursing curriculum, led by recommendations from the Nursing and Midwifery Council, has shifted attention to 'competencies' as the outcome of nurse education and in an era when patients' views are increasingly seen as important, their views on 'nursing competency' are important to investigate.

## **Assessment of Practice**

The problem of how student nurses' clinical practice might be assessed is a longstanding one. Clinical assessment in nursing has developed from classroom based displays of basic practical skills, through the behavioural checklists of the 1970s and 1980s, to a system of continuous assessment in the clinical environment (Aggleton *et al* 1987). Since the introduction of Diploma Programmes in the UK in 1992 (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1986; United Kingdom

Central Council for Nursing, Midwifery and Health Visiting 1999), there has been an increasing emphasis placed on clinical practice assessment contributing directly to academic qualifications. This issue raises the problem of discriminating between different levels of practice and the importance of having 'approaches to assessment that are valid and reliable and acceptable to the profession and the public' (Norman *et al* 2000:1). The proposed research will focus not only on how clinical assessment can be made acceptable to the public but also on how the public might be involved in clinical assessment itself.

This research is significant, as it will involve service users in identifying their construction of, and views on, nurses' competence in the clinical setting. There has been ongoing work evaluating patients' assessment of students in simulated environments (Fowell and Bligh 1998) but sparse evidence of patient involvement in the clinical situation. More fundamentally there is currently a poor understanding of how patients conceptualise competence.

## **The study**

The purpose of this research is to generate a grounded theory of patients' construction of competence of nurses<sup>2</sup>. This is based on research guided by the primary research question: how do patients construct the concept of competence of nurses? The purpose was to develop a theoretical understanding of patients' views of nursing competence. Information and evidence for future planning of patient involvement would then be made available.

This study evolved from personal and professional interest in how nurses are assessed for fitness to practise. Interest in this area began when working on a research project that examined the validity and reliability of methods to assess the competence to practise of

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<sup>2</sup> Nurse is defined for the purpose of this research as a registered nurse or pre-registration student nurse.

pre-registration nursing and midwifery students in Scotland. A number of stakeholders were involved in the assessment of students in this study, with the notable exception of the patient. The research recommended (Norman *et al* 2000) that research was needed to test the feasibility of patients' assessment of nursing students' clinical competence. When the literature reporting patients' views was reviewed, it was clear that there was a paucity of evidence indicating patients' conceptualisation of competence that would underpin the assessment of practice from their perspective. As a number of health care disciplines, including nursing, are now beginning to implement patient evaluation of professional competence, this study seemed timely in its development.

## **The Context**

The context of this study is two NHS Hospital Trusts in central Scotland. Both hospitals are teaching hospitals with a wide range of clinical specialities, which was felt to be important for the development of a theoretical sampling strategy. Preliminary data collection was undertaken in general medical and surgical areas. Participants were recruited to the study on the basis that they had experience of nursing care rather than because of any clinical diagnosis or because of age or gender. A theoretical sampling strategy was then developed to include patients in three specialty areas: renal dialysis; cystic fibrosis and diabetes care.

## **The Research Approach**

A qualitative approach was adopted to explore patients' views on nursing competence within the hospital setting. In-depth interviewing following a topic guide was the predominant mode of data collection, although field notes were documented after every interview. Twenty seven patients participated in the study. The principles of grounded theory were used to guide data collection and analysis.

Judging nurses' competence is not an essentially objective experience but is complex and is undertaken within the social world - in this study, the world of the ward. Patients evaluating nursing cannot be divorced from the complex relationships that patients have with nurses. Patient views were examined in the tradition of symbolic interactionism, which acknowledges this complex process of making sense of the world.

## **Presentation of Data**

Following this introduction to the study, Chapter Two will present a review of the literature. This literature review aims to highlight inconsistencies or gaps in current understanding of assessment of clinical practice. The first part of the literature review will focus on the purpose of the assessment of practice placements. It also includes an overview of current methods of assessment and the evidence relating to this in the health care literature. The second part highlights some of the criticisms and controversies in competence assessment. Lastly there is a focus on patient involvement in assessment.

The majority of this literature comes from the disciplines of nursing and medicine and reports on research from a number of different countries, but predominantly the UK. In the UK there has been a particular interest in the assessment of practice placements in nursing and medicine in the last ten to fifteen years with changes to nursing and medical pre-registration education and, particularly in medicine, reforms to post basic education training and revalidation for the professional register. There have thus been significant numbers of papers and research projects on this topic.

Chapter Three will discuss methodological issues relating to this study, the principles of grounded theory, and a review of the work that has been influential on this study. Chapter Four will then provide a discussion of the approach to this particular study, where the process of data collection, theoretical sampling and analysis is described in detail.

Chapters Five, Six and Seven will provide a full account of the findings and emerging theory. Chapter Five: "Knowing the Score - Becoming a Patient", highlights the importance of becoming immersed in hospital life, learning to become a patient and the social control, imposed by both patients and nurses, that hospital inpatients experience. Chapter Six focuses on recognising good nursing: actions, roles and values, the interpersonal skills which were highlighted as the most important factor for patients in the judgement of care. Chapter Seven describes patients' reflections on competent nursing and develops theoretical categories with which to understand these views. Throughout these chapters, extensive use of direct quotation will be made in order to 'bring alive' the theoretical components that have been developed.

Chapter Eight 'Between you and me' – perceptions of competence: public and private is the discussion of a core category developed from the data. This core category will allow the relationship between the three major categories to be explored; it is this relationship that brings meaningful understanding to the concepts developed in this study and is the contribution to existing knowledge. The properties of the core category highlighted the important processes for patients' judgement of competence of nurses and the part these play in explaining the stories of patients. The properties that developed are; *context; working together: the interpersonal dimension and rationales for private expressions of competence.*

Chapter Nine concludes the thesis by presenting issues that arise from the thesis and highlighting important findings for practice and education. This will be set in the context of the current political and professional climate and suggestions for further research in this area identified. Although this study focuses on nursing, the findings are important not only for nursing but for other health care disciplines that would like to involve patients in evaluation of professional competence. To reflect this, issues that may go beyond nursing will also be highlighted.

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# CHAPTER 2

## LITERATURE REVIEW

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### **Introduction**

The purpose of this chapter is to review the literature on competence, how this concept is perceived in relation to the practice of nursing and how perceptions vary as to the meaning and relevance to the development of the profession. This is not intended to be a systematic review of literature but a focused examination of issues relating to the concept of competence that have particular importance for the interpretation of data presented in later chapters. Comprehensive reviews of the literature have been published elsewhere (Giot 1993; Sharp *et al* 1995; Norman *et al* 2000; Redfern *et al* 2002) and a systematic review of the literature on clinical competence assessment in nursing has recently been published (Watson *et al* 2002a). Although relevant literature is cited from other health care professions, most notably medicine, literature will primarily focus on competence assessment in nursing, as although comparisons can be made between professions, there are some professional differences that mean the transferability of evidence from one profession to another is not always helpful.

### **Search strategy**

A broad review of the literature was undertaken in the areas of competence in nursing and other practice based disciplines. An electronic search was undertaken using CINAHL, MEDLINE and Web of Science. All were utilised in their internet online format. Keywords used included: good nursing; competence; education; assessment and

nursing. These were used in different combinations. The search date parameters were 1990 to 2004. This was complemented by a manual search of relevant journals held in University of Edinburgh libraries. Reference lists of papers obtained through these searches were examined for any further relevant references. This revealed several studies not available in the university library which were retrieved using the inter-library loan system.

## **Assessing practice placements**

In programmes of education practice placements appear in many forms across disciplines, for example, field placements, internships and clinical placements. Toohey *et al* (1996), a group of educationalists who review the methods of education in practice, and identify that the aims of practice placements include:

- Giving students an insight into the world of work and helping them to integrate into the work environment
- Developing professional skills
- Developing interpersonal and social skills
- Linking theory to practice
- Enhancing employment prospects of students.

(Toohey *et al* 1996: 216)

However, there is confusion about the contribution practical experience can make to higher education and in almost all cases assessing practice placements is seen as problematic (Toohey *et al* 1996).

There are many different types of learning outcomes for these placements, and how to assess practice is fiercely debated. No one solution has been agreed either across disciplines or within them. Much of this disquiet comes from the difficulty in marrying traditional assessment, that is knowledge based assessment that allows the comparison



and ranking of students, with the kinds of outcomes that may derive from practical experience, where there is no certainty of reproducing the same experience for each student. A number of methods of assessment in the workplace have been put forward by educationalists and the main models are highlighted by Toohey *et al* (1996).

- The attendance model: This model focuses on the student's attendance. The supervisor confirms that the student has attended the placement and that performance was satisfactory, but no guidance has been developed on what constitutes satisfactory performance.
- Work history model: This is considered more sophisticated than the attendance model. Students identify and document the tasks they have undertaken and indicate what they have learnt from them, for example with the use of journals. This model has been used in diverse professional education from engineering to business studies. It is often used in placements where it is difficult to organise a structured experience for students. However, one difficulty of this method is that there is little guidance as to how these accounts of learning are assessed.
- Broad abilities model: This model is characterised by the development of broad abilities, such as critical thinking and interpersonal skills. This model has been useful in integrating theoretical and practical aspects of courses, as identified abilities are so broad that both theory and practice can contribute to their achievement, although there are of course issues with setting abilities so wide that they become worthless. This model allows students on diverse placements to be assessed using the same criteria.
- Specific competencies model: This is a very structured approach to assessment. Specific tasks and roles are identified and the practice placement is organised to allow the student to experience the full range of learning opportunities that will enable them to achieve the set competencies. Competence may be assessed as

pass/fail or on a rating scale. Students may also be required to submit a written paper to show the knowledge underpinning practical competence.

- Negotiated curriculum model: This model promotes the development of an individual curriculum designed and assessed in partnership between the student and the supervisor. It is based on adult learning theories, and is put into operation through the development of a learning contract. Although the learning contracts are developed at an individual level their outcomes must meet the broad aims of the course of education.

There are examples of all of these models being used in health care but currently, the most utilised of these in the UK is the specific competencies model. This model is utilised across disciplines and at all levels from the undergraduate curriculum to the re-registration of senior practitioners. This chapter will focus on competence based education and the current debates in its implementation.

## **Purpose of assessment of practice in health care**

It may be helpful before examining competence based assessment to highlight the purpose of the assessment of practice in the health care professions. One purpose of practice assessment is to set rigorous procedures to assess the practice of individuals that make the process of self regulation more transparent. Initiatives to improve care, investigation of under-performance and the self regulation of health professions 'stand or fall on validated methods to evaluate professional competence and performance' (Crossley *et al* 2002: 800). Competence assessment is used in the health service both to evaluate the practice of students and for the periodic revalidation or continuous monitoring of practice of qualified practitioners. Student learning programs in nursing must now be fifty percent practice and fifty percent theory, this has been a further imperative in the development of valid and reliable means of assessing practice placements in nurse education

A further purpose of assessment, by way of professional self regulation, is to ensure the provision of quality care to patients. Being 'safe to practise' is considered by some to be a central outcome of medical education (Godfrey 1995). Others do not consider safety to be enough, but suggest it is quality of practice which is the central issue. (Jinks and Morrison, 1997).

Calman (1993) suggests that the outcome of medical (clinical) education needs to be clarified in the context of providing care within the National Health Service (NHS). Professionals have also to conform to what service users want and what they are encouraged to want through policy developments (Scottish Executive 2000, 2003; Department of Health 1998, 2000)

people today expect more. They want the right care at the right time and in the right place. They want to be involved in decisions about what is best for them. They want safe and consistent healthcare in modern premises. (Scottish Executive 2003: 1)

Rushforth and Ireland (1997) also identify concerns about the impact on education of local purchasers who are increasingly making demands on education providers to fulfil their own agenda.

## **Competence Assessment**

Although the purpose of practice assessment is clear, the process is not. Traditionally, assessment of practice in health care was undertaken by experienced practitioners from the same profession: a nurse assessing a nurse and a doctor assessing a doctor. Not only have the methods of practice assessment changed and become more rigorous over recent years, questions have also arisen about who should assess the practice of a profession. New procedures for the revalidation of medical staff have led, for example, the Royal College of Obstetricians and Gynaecologists to ask for evaluation of doctors from a variety of professionals and patients, in order to gain insight into competence to practise from a number of perspectives (Royal College of Obstetricians and Gynaecologists 2002). This type of revalidation requiring written evidence from colleagues or other

professionals is not currently required in nursing<sup>3</sup>. These issues will be addressed in the rest of this chapter.

Competence assessment was developed in North America in manual occupations where academic testing was not deemed to be required; rather individuals were tested on job related skills. These developments have been influential and were introduced in the UK with the development of National Vocational Qualifications which are vocational courses rather than 'academic' courses (Watson *et al* 2002a).

Hyland (1993) gives a description of the evolution and limitations of the competence based approach in education. National Vocational Qualifications (NVQs) and competence based assessment were introduced in 1986. The impact of a competence based strategy for education has now gone beyond its original vocational remit and is evident in education from school to higher education. This type of education has been criticised particularly because of its foundation in behaviourist learning. To determine statements of competence, functional analyses of jobs are undertaken and the focus is placed on outcomes. The NVQ courses are also not necessarily linked with an educational course. The assessment of competence in the workplace, independent of any specific course, was emphasised by The National Council of Vocational Qualifications (NCVQ) (National Council of Vocational Qualifications 1989). This idea of specifying what has to be achieved and measured, it is claimed, is nothing more than behaviourism and the origins of competency based education can be clearly seen in this tradition (Hyland, 1993).

Within competence based education there have been some moves forward in developing away from simplistic notions of competence as performance of basic tasks, but there is still limited evidence of links being made between educational programmes and competence in the workplace, although the introduction of reflective practice discussed

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<sup>3</sup> Under the guidelines for post-registration education and practice (PREP), nurses are required to meet practice and continuing professional development standards and keep a professional portfolio (Nursing and Midwifery Council 2002) which may be requested by the Nursing and Midwifery Council at periodic three year registration. Proof of competence is not currently required.

later in this chapter does go some way towards linking theory and practice. There is the assumption that the assessment of competence equates with competence itself. If an individual can perform competently, that individual must have the appropriate knowledge underpinning their action. Within the competence education tradition there seems to be no reason to assess knowledge or understanding unless it is related to the tasks to be performed.

Competence based education was introduced to nurse education in the UK in the early 1990s with the introduction of the Diploma Programmes or 'Project 2000' as it is commonly known. These programmes were developed to give all nurses a common foundation for nursing studies and branch programmes that would lead to specialisation in one of four areas: Adult, Child, Mental Health or Learning Disability nursing. The programmes run over three or four<sup>4</sup> years and a minimum academic qualification of the diploma of higher education (Dip HE) as well as the appropriate nursing registration are awarded. Nursing students have become supernumerary in staffing numbers and are no longer employees of the NHS during practice placements; the focus of courses is on education rather than training.

## DEFINING COMPETENCE

A central question that has to be answered is: what is competence? A particular problem with the introduction of competence based education in nursing is the lack of clarity in the definition of competence. There has been much debate in the nursing and health care literature about this very question (Giot 1993; While 1994; Bradshaw 1997; Milligan 1998). Runciman (1990) identifies that the definition of competence has long been debated and is the subject of an extensive literature. Bradshaw (2000) suggests, in an historical view of competence in British nursing, that the traditional view of competence (pre-1979) was to produce a bedside nurse. This not only related to the ability to

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<sup>4</sup> The majority of student nurses undertake the diploma programme which is completed in three years; undergraduate programmes may take four years to complete.

undertake practical procedures but also related to aspects of a nurse's character, such as professional etiquette. It can be argued that since the *Nurses', Midwives' and Health Visitors' Act of 1979* (Nurses', Midwives' and Health Visitors' Act, 1979) and the subsequent professionalisation of nursing, there has been a clouding of the role of the nurse, not least what is meant by competence (Bradshaw, 2000). This is evident when trying to determine a definition of competence from the literature. Girot (1993) describes it as being '...over defined rather than ill defined' with the literature seeming 'contradictory and confusing' (Girot 1993: 83).

Coates and Chambers (1992) amongst others argue that there is some disagreement about the nature of competence in nurse education. Competence can be considered to be an objective concept that can be measured, standardised and validated through the use of examinations and assessment instruments. However, Benner's (1984) study of skill acquisition in nursing in the United States of America (USA) suggests a different view. This study directed by the principles of phenomenology identified and classified competencies in nurses practice into seven domains and identified the development of nursing practice in five stages, from novice to expert. Benner's (1984) work has been a seminal study in nursing theory as it attempts to describe and categorise nursing and developed a model of competence in nursing practice. This is highlighted by this model, in a review of assessment practises in Scotland, being identified as the theoretical basis of five out of the seven of the clinical assessment documents in Scotland's nursing diploma courses between 1992 and 1996 (Calman *et al* 2002). This work was seen as a ready made framework for the assessment of competence however by the 1996 revalidation of nursing courses in Scotland all but one institution dropped the framework, suggesting that it was too complex lengthy and difficult to understand for clinical staff to complete (Calman *et al* 2002). Although Benner (1984) made a valuable contribution to the field her work was based on a small number of interviews in the USA in three geographically close hospitals, this work was taken up by nursing educationalists as an easy checklist for assessment, something the framework was never designed to do, as a result it failed to produce a practical solution for assessment of



competence that was being sought in the early 1990's when the diploma programmes were being devised. Benner argues that not only the performance of clinical skills is important but also the values, attitudes and intuitive skills associated with these skills. However, there is some debate about whether these personality attributes can (or should be) measured objectively (Benner, 1982).

This debate is also highlighted in the medical education literature. An examination of the different ways in which medical practice can be divided up for assessment indicates that 'competencies can be viewed in two ways: as attributes or as tasks' (Crossley *et al* 2002: 801). When considering the assessment of competence there is the assumption that competence can be divided into individual competencies and that the sum of the parts makes a whole.

Definitions of competence that have been offered are often complex, and are summarised by Worth-Butler *et al* (1994). Drawing on these definitions the authors offer a holistic model of competence:

“...competence involves the mastery of requirements for effective functioning, in the varied circumstances of the real world, and in a range of contexts and organisations. It involves not only observable behaviour which can be measured, but also unobservable attributes including attitudes, values, judgmental ability and personal dispositions: that is - not only performance but capability.” (Worth-Butler *et al* 1994: 226)

Unlike a definition suggesting that competence is a single entity and is measurable as such, this model suggests it is complex in nature, and includes knowledge, skills, values and attitudes, and therefore may need several different assessment measures to satisfy the whole model. This has led to the suggestion that more than one method needs to be used to assess competence (Worth-Butler *et al* 1994; Norman *et al* 2000). Norman *et al* (2000) examined the validity and reliability of clinical assessment instruments to assess the competence to practise of student nurses in Scotland. This two year study involved comparing items in the selected tools with statutory competencies for nurses and midwives, collecting assessment data from a sample of 257 nursing and 43 midwifery students in four educational institutions and administering additional assessment measures (the Nursing Competencies Questionnaire (NCQ) and the Key Areas

Assessment Instrument (KAAI) to the total student sample (and to their lecturers and practice assessors) at two time points which were six months apart. The focus of the study was the programme-specific clinical competence assessment tools but by testing these tools evidence on the validity of other methods of competence assessment was gathered. Validity of the methods was assessed, primarily, by calculating multivariate and univariate correlation coefficients between them. Correlational analysis of data collected on students showed that there is little or no relationship between most of the clinical competence assessment methods that were in use, or between these methods and those introduced by the research team (Norman *et al* 2000).

This finding (Norman *et al* 2000) supports previous research, particularly in medical education and confirms that the different methods address different abilities. A clear finding from this study is that no single method is appropriate for assessing clinical competence. A multimethod UK-wide strategy for clinical competence assessment for nursing and midwifery is needed if we are to be sure that assessment reveals whether or not students have achieved the complex repertoire of knowledge, skills and attitudes required for competent practice.

Currently the selection of professional competencies for acquisition on registration is made by expert opinion and governed by regulatory bodies such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC). Within nursing, advanced practice competencies are not professionally regulated as advanced practice roles are not currently legislated for. However, a number of institutions including the Royal College of Nursing (RCN) are working towards developing advanced practice competencies. The International Council of Nurses (ICN) has developed a framework of competencies (International Council of Nurses 2003) for the generalist nurse, to assist in clarifying the role of the nurse and provide guidance in the role and scope of nursing practice internationally, particularly to countries beginning to develop the role of the professional nurse (Hancock 2004).

In the UK, nurses have looked to statutory bodies for guidance in determining the definition of competence (see Phillips *et al* (1994)). Competencies were set out in the



Nurses' Rules (Nurses', Midwives' and Health Visitors' Act, 1979) and were introduced into UK nurse education by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)<sup>5</sup> in 1983. Although this setting down of national minimum standards was a significant development in nurse education, it has attracted criticism. It has been suggested that the competencies are not defined sufficiently to be helpful (Bradshaw, 1997). There is also a concern that these competencies are seen as levels of competence that have to be reached as a minimum but there is no requirement to develop beyond these (Phillips *et al* 1994).

In July 2000 a new set of competencies was published by the UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 2000). These are a revised set of outcomes to be reached by the end of year one of a pre-registration nursing programme and competencies at the point of registration in year three or four. These competencies are generic to all nursing programmes and it is not clear therefore how helpful they are in giving specific guidance to those developing new curricula in the wake of the Fitness for Practice Report from the UKCC Commission for Education (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1999). The profession has validated these competencies through a consultation process and therefore it could be generally accepted that they do provide a national standard of competence on registration, although there is still concern that the NMC has provided little guidance on how these competencies can be assessed in a valid and reliable way (Dolan 2003).

The Fitness for Practice Report from the UKCC Commission for Education (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1999) has been a key influence on nursing education in the UK. The report reviewed current evidence on the success programmes of nursing education in producing students that were fit for practice and purpose and academic award. The report made recommendations about the future of pre-registration nursing programmes and specifically about the development

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<sup>5</sup> In 2002 the UKCC became the Nursing and Midwifery Council (NMC)

and assessment of competence. The report identifies that in nursing these are considerable problems with the definition of competence and that assessment of competence cannot be reduced to the student's ability to carry out tasks. Subsequently the report suggests that strategies to assess competence need to be improved to ensure that students can practice safely and effectively (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1999).

The report goes on to develop a definition of competence:

‘...the skills and ability to practise safely and effectively without the need for direct supervision’ (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1995: 35).

This report gives a clear indication that, for the UKCC (now NMC), competence is imbedded in UK nurse education.

## OVERVIEW OF METHODS OF COMPETENCE ASSESSMENT

In view of the complexity of assessing competence there are a number of reported methods by which competence is assessed in pre-registration nursing education. A brief overview and critique is given below. However, a historical overview may be useful to put current methods in context.

Before 1971, student nurses were assessed in classroom based displays of practical skill along with checklists of procedures to be mastered in the clinical placement. In the 1970s ward based practical assessments were used to assess students in four areas: aseptic technique; administration of medicines; patient care and ward management. In the 1980s, behavioural checklists replaced these practical assessments and continuous clinical assessment using locally developed instruments was the focus of assessment. This reflected a shift in ethos from performance of tasks to a ‘total patient care’ approach and to the use of objective assessments, although the reality is that instruments were rarely evaluated for validity and reliability (Sharp *et al* 1995, Norman *et al* 2000). The focus of pre-registration education was on the continuous assessment of nursing students both academically and practically, as it was considered unsatisfactory that only

a snapshot of clinical competence should be assessed (Aggleton *et al* 1987). These continuous assessment tools were primarily concerned with assessing observable behaviour within the clinical setting using scales or grades (Cudmore, 1996). Although they are considered an improvement on previous methods of assessment, much criticism has been levelled at them. In particular, it was argued that fundamental nursing skills that are not observable in a behavioural model were not being assessed adequately. White *et al* (1993) found continuous assessment of student practice to be problematic.

Once a nurse was registered there was no *formal* requirement to be reassessed for competence (which is still the case today). It is only recently with moves in the UK towards the development of advanced practice competencies (Royal College of Nursing 2002) and pressure from policy makers to ensure the protection of the public that competence assessment beyond pre-registration programmes has become an issue for nursing and other health care professions. Thus, much of the evidence presented relates to pre-registration education and not continuing or advanced practice.

## CURRENT METHODS OF ASSESSMENT

This section gives an overview of the current main methods of assessment used in assessing practice. These are: observing practice and assessment using rating scales and objective simulated assessment; reflection and self assessment.

### OBSERVATION

Assessment of nursing practice is usually based on observation in the clinical setting, but since the 1970s, in nursing and medicine, observation and assessment has also been undertaken out of the practice setting in simulated conditions.

#### *Observation in the practice setting*

Observation in the practice setting has advantages as assessment is undertaken in the clinical environment and allows the assessor to see the student in the ever changing environment. However, it has been reported that this also has some limitations including difficulty in comparing student experience, the pressure of workload for the assessor,

assessment and learning in the same situation, bias towards the student if the assessor has knowledge of previous problems, difficulty in separating the role of supervisor and assessor and reluctance to fail students (Wood 1986, Duffy 2004). For these reasons there has been concern that assessment in practice is unreliable. Some suggestions have been made to improve reliability of assessments, by preparing/training assessors in assessment in the workplace and the development of competencies and criteria against which students are assessed (Gilmore 1999). Assessment by rating scales is the most common way in which nurses are assessed in the UK. However, there is not a 'gold standard' assessment instrument and education institutions develop their own assessments, which can lack validity and reliability (Norman *et al* 2000)

The use of scales and the grading of students against lists of skills has long been heavily criticised for their reductionist nature (Fletcher 1985; Darbyshire *et al* 1990; Benner 1982). It is considered inappropriate to reduce nursing to a set of skills and behaviours. A more holistic approach to assessment should be made that takes account of the individual student's experience and knowledge, the environment and the psychosocial aspects of student performance such as attitude and caring skills. The reliability of these scales has also been called into question (for example: Bondy 1983; Norman *et al* 2000; Watson *et al* 2002a) as they are open to interpretation by each assessor.

Instruments developed to assess students were found to be open to subjectivity and ambiguity. Often, tools that have been utilised for continuous assessment have remained behavioural in approach to counter this criticism of subjectivity, for example, the work of Bondy that has been used extensively in the UK as a theoretical basis for assessment instruments (Calman *et al* 2002). Bondy's work was developed in the 1980s in the USA (Bondy 1983, 1984) and was a seminal piece of work on the in the search for valid criteria against which to evaluate student nurses. Bondy used video recordings of students performing nursing activities and five different levels of competence from independent to dependent clear were developed. Criteria were identified at each scale point and this improved the accuracy and reliability of assessment (Bondy 1984). Body's ward has been further developed by researchers in Australia (Donoghue and Pelletier

1991). Although in this study, which further developed three of Bondy's dimensions reliability and validity of the instrument proved disappointing (Donoghue and Pelletier 1991). Body's work was further developed in the USA with the development of the Clinical Evaluation Tool (CET) (Krichbaum *et al* 1994). Their criticism of Body's work was that it focused on process rather than outcome and was therefore not universally applicable (Krichbaum *et al* 1994). The CET instrument was developed to counter this criticism it combined Bondy's criterion reference standards and contains descriptors of excellent care as outcomes of learning, this instrument was validated by a group of experts however more validity and reliability testing is needed (Krichbaum *et al* 1994). One notable development in the UK is Cox *et al*'s (1998) work on the development of a assessment scheme for nursing practice in Luton, England. This scheme uses a task based skills acquisition manual, competence is rated by qualified nursing observing student in practice, students also rate their own performance and the two ratings are compared, students must pass 75% of skills by the end of the foundation programme to pass (Cox *et al* 1998). The scheme is used as continuous assessment and branch programme students reach full competence in specific skills through a learning contract (Cox *et al* 1998). The development of this scheme it is still firmly behaviouralist in approach and can draw criticism for that.

Observable has meant measurable to the developers of assessment scales and this approach has attracted criticism. Darbyshire *et al* (1990) consider outcome based and behaviouralist assessments to lead to a fragmentation of practice in the assumption that when all the pieces are added together they equate to competent nursing practice. Phillips *et al* (1994) consider continuous assessment to be a fairer system than the one-off practical test system although it has flaws, such as poor discrimination of levels of performance and ward reports that are open to interpretation and often not completed properly.

The lack of effectiveness of instruments is highlighted by the finding that education institutions participating in one study could not identify an occasion when a student was removed from a course of study because of failure to meet the required level of

competence (Calman *et al* 2002). This appeared to be because of the difficulty in recording objectively the failure of a student, so clinical staff gave the student ‘the benefit of the doubt’. This has been supported by a recent NMC funded study (Duffy 2004). The complexity of instruments and lack of training for clinical staff in their use also played a part in practice assessors’ failure to fail.

#### *The Structured Clinical Examination (OSCE) and simulation techniques*

There has been a move towards assessments being more objective and fair (McKnight *et al* 1987) in an attempt to make assessments a summative part of coursework. The most documented attempt is the Objective Structured Clinical Examination (OSCE). This was a technique developed in the 1970s in Scotland originally for the clinical skills assessment of medical students (Harden *et al* 1975). Testing for validity and reliability for the OSCE has been undertaken primarily in Medicine, therefore evidence to support the use of the OSCE and simulation will be drawn from the medical literature. Its use has continued in medicine and it is considered a valid and reliable assessment of clinical skills (Morrison *et al* 1996; O’Conner and McGraw 1997; Donnelly *et al* 2000). The OSCE is not just concerned with the assessment of psychomotor skills. Davenport *et al* (1998) found the OSCE in dentistry education to be particularly effective in the assessment of communication skills.

The OSCE typically consists of a number of ‘stations’ each with its own clinical problem which may range from history taking to a technical skill. Students are assessed by an examiner using a standardised checklist. As this checklist is detailed, reliability between examiners has been reported as good (Donnelly *et al* 2000; Sloan *et al* 1995). A certain amount of time is allocated to each station and students rotate through stations during the exam.

The use of simulated patients in the OSCE allows students to be assessed on equal terms. ‘Patients’<sup>6</sup> are trained in standard responses and complaints of symptoms, and

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<sup>6</sup> ‘Patients’ may be actors, academic staff or students playing the role of patient for the purpose of the assessment or ‘real’ patients recruited for the OSCE or simulation.



may be trained in the assessment of students. Roberts *et al* (1992) suggest that simulation can be used alongside reflection for teaching and learning purposes in nursing education. This is supported by Pololi (1995) who saw it as a safe environment for medical students to learn.

Ross *et al* (1988) consider that the OSCE:

“....appears to be a method of assessing clinical competence which is objective in nature, fulfils criteria of validity, reliability and practicality, has the potential for testing a wide range of knowledge and skills and can accommodate a large number of examinees in one examination period” (p46).

The OSCE may appear to be the answer to all the problems of clinical assessment of student nurses and midwives. Why then is it not being practised in all departments of nursing in the country? There are a small number of papers on the subject of the OSCE in the nursing literature most of which are North American and in particular are associated with McMaster University in Ontario (Norman *et al* 2000). Few examples of the use of the OSCE and simulation in the UK are reported in the nursing literature, even though a number of institutions in the UK are known to use the technique (Wildman and Reeves 1997) this possibly reflects the use of the OSCE in nursing for teaching or formative learning experiences and assessment rather than for summative assessment. Papers that are published report outcomes of individual simulation exercises (Wildman and Reeves 1997; Bryans and McIntosh 2000; Ebbert and Connors 2004; Bryans 2004) and although these evaluate the technique with expressions of satisfaction from both students and educators and report that educational aims have been met they do not examine issues of validity and reliability citing medical literature to support their use. Therefore the nursing literature provides little evidence on which to evaluate the OSCE or simulation.

There is conflicting evidence about the OSCE and the use of simulated patients in clinical assessments, and some genuine concerns about the technique. The transferability of the skills assessed in the OSCE has been questioned. Students are given a score for their ability to perform a task in a particular (and well controlled) environment at a particular time. It has been argued that this will not give a clear picture of a student's

performance in a 'real life' clinical situation, when the patient and the environment may change from one minute to the next. Much of the literature evaluating the OSCE has been done within medical education and it is this research that will be examined.

There has been concern about the low correlation between students' scores on the OSCE and clinical knowledge (Jansen *et al* 1996; Gomez *et al* 1997) and between assessment using simulated patients and clinical performance (Coliver *et al* 1991) in medical education. It is this lack of reality that, for some, is the greatest downfall of the OSCE and the use of simulated patients. Students may be considered as competent in the controlled confines of an academic institution but in performing those skills in an unpredictable clinical area they may not. This has implications for the students' self-esteem and expectations of themselves in the clinical area. It may also lead to conflict between the clinical areas and the academic institution if a student is sent to clinical areas having been deemed to be competent in certain skills without having undertaken them in the 'real world' environment of the ward..

The grading of the OSCE may also cause concern. The literature suggests (although it is not clear in all papers) that the marking is done by academic staff from the students' institution and not by clinical staff. Clinical credibility of academic *nursing* staff has been in question (Goorapah 1997) and their ability to have a realistic perception of what happens 'out there' may colour marking schemes and marking itself. This may be an example of the divide in what is taught and expected in an academic department and the skills that students really need in the clinical situation as noted by Melia (1987) and still seen as a concern with current courses (Elkan and Robinson 1995).

It has been suggested that there is no test of initiative or ability to transfer skills to another situation and no assessment of teamwork within the OSCE framework. Both of these would be considered essential to the role of the practitioner in today's NHS. The OSCE is recognised as being more stressful than traditional forms of assessment (McKnight *et al*, 1987). It is also costly in terms of finance and time, particularly when large numbers of students are involved. Given the large cohorts in many nursing departments - upwards of 400 students per year in some institutions - it would be a very



expensive assessment strategy to put in place. Yelland (1998) however believes that the cost in time and money is outweighed by the validity and the reliability and degree of control and problem selection offered by the use of simulated patients.

Simulated situations using actors or trained patients have been used to assess successfully students' communication skills (Arthur 1999). While *et al* (1998) report the success of using actresses as simulated patients for a care planning exercise. Despite this, the use of simulation has many of the same limitations as the OSCE and has only seen limited use in nurse education in the UK.

New technology has allowed the development of virtual reality programmes for the teaching and assessment of clinical skills. Although this is a new development it is an exciting alternative (Smith *et al* 1999). However, there are current limitations: firstly, there needs to be a full evaluation of validity and reliability and secondly there is a limitation of technology and a lack of readily available software.

Although there are limitations to the use of the OSCE and simulation, they certainly have their use in providing baseline competence in clinical skill before the student enters the 'real world' clinical environment, and therefore may well be an underused resource in nursing education particularly in the early stages of education (Norman *et al* 2000).

#### REFLECTIVE PRACTICE<sup>7</sup>

The introduction of diploma courses in the early 1990s saw the consideration of more holistic assessment of student nurses and midwives, with the use of critical incidents, profiling and reflection (Carr 1996; Gormley 1997; Jasper 1995, Norman *et al* 2000). This type of assessment fits with theoretical work on the nature of nursing knowledge. For example with the aesthetic and personal knowledge dimension in Carper's fundamental patterns of knowing (Carper 1978). Professional and personal development

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<sup>7</sup> Reflective practice may be defined as 'a process of reviewing an experience of practice in order to better describe, analyse and evaluate, and so to inform learning about practice' (Boud *et al* 1985: 10).

overlap in nurse education and the use of portfolios may assist the students to reflect on and document both of these aspects of development as other methods focus primarily on professional development (McMullan *et al* 2003). This is one method of assessment that is being used extensively at post-registration level. It is a requirement that nurses keep a portfolio for re-registration purposes (Nursing and Midwifery Council 2002).

Reflection in terms of student learning has been considered beneficial to students in terms of learning and personal growth (Shields 1995). It can allow the integration of theory and practice (Sharp *et al* 1995; Scholes *et al* 2004) and is looked upon as a positive addition to nursing education and practice (Runciman 1990). Reflective practice also supports the development of the nurse as a 'knowledgeable doer' which was advocated in the implementation of the diploma courses of education (Runciman 1990).

Although these techniques have been felt to give a wider view of students' performance they are not without their problems. The reflection process is difficult to learn (Powell 1989; Houston *et al* 1997) and it may be considered unfair to assess summatively students this way. Virtually all of the techniques described use the written medium and writing to assess competence (Runciman 1990) and can therefore be considered a test of theory and not practice. It may also be threatening to students to reveal narratives of incidents, particularly if the student is aware that it shows them to be less than competent. The fear of having this documented in a written form may lead students to be untruthful in their writing.

How portfolios<sup>8</sup>, one of the commonest ways of integrating reflective practice into nurse education, can be assessed is questioned. This type of writing is individual and personal and is difficult to standardise between students. In addition, low inter-rater reliability has been found between assessors of portfolios (McMullan *et al* 2003). It has been suggested that portfolios should not be assessed only by qualitative measures, but with qualitative approaches (Snadden 1999). Summative assessment of students with this method is

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<sup>8</sup> A portfolio can be defined as 'a collection of evidence, usually in written form, of both the products and processes of learning. It attests to achievement and personal and professional development, by providing a critical analysis of its contents' (McMullan *et al* 2003: 288).

greeted with caution as using the approach as an instrument for learning and assessment may be contradictory (McMullan *et al* 2003). If portfolios are to be used for assessment purposes then students and assessors need clear guidelines for writing and marking.

Reflection techniques are considered appropriate for those with experience of life and work (Glen and Hight 1992). It may be questionable that pre-registration students have had enough clinical and, in the case of school leavers, enough life experience to be able to reflect to the depth that is required. These techniques also require the students to be motivated and self directed and for the institution to allow their development in a model of adult education (Glen and Hight 1992).

The implications of the introduction of reflective learning for the institution are also significant in terms of resources required to educate staff, mentors and students. This type of learning often happens in small groups and also has implications for staff workload (Nicholl and Higgins 2004). The validity and the subjectivity of these techniques can be questioned (Runciman 1990; Glen and Hight 1992), and Purvis (1990) and Malik (1993) also express concern that the reliability of this method of assessment is questionable, as there may be doubts about how truthful students have been in their records. In light of Malik's evidence, the English National Board for Nursing, Midwifery and Health Visiting (ENB) reviewed its use of portfolios and commissioned research to evaluate the use of portfolios in pre- and post-registration nurse education (McMullan *et al* 2003). The recommendations of this evaluation were that specific written competencies are essential to focus clinical learning and to aid linking of theory and practice but must be tailored to the student's progression in the course, otherwise students found the process irrelevant to their needs. Specific and simple outcomes are useful for students early in the course and analytic and reflective competencies in the later stages of programmes of education or at post-registration level (McMullan *et al* 2003).

#### SELF ASSESSMENT INSTRUMENTS

A small number of papers report the use of self assessment in the evaluation of competence in nursing (Bartlett *et al* 1998; Watson *et al* 2002b; Meretoja *et al* 2004).

All report that their instruments have validity and reliability. Watson *et al* (2002b) report that their instrument is sensitive over time and Meretoja *et al* (2004) that theirs, developed in Finland and based on Benner's 'Novice to Expert' model (Benner 1984), can discriminate between levels of practice. These instruments can also be criticised on the same grounds as other behavioural scales as previously discussed.

However sensitive, valid and reliable these instruments are, Norman *et al* (2002) report that although self reporting of competence by pre-registration students was significantly statistically consistent between two self assessment instruments, these scores did not correlate with any other competence measure, either assessment by the university lecturer or the practice assessors. This finding has also been reported elsewhere (Clapham 1998; Loftmark *et al* 1999). Self assessment was considered to be measuring a different domain of competence than other instruments. This evidence continues to suggest a multi-method approach to competence.

## SUMMARY

The main approaches to competence and its assessment have been summarised by McMullan *et al* (2003). The first approach they identify is the *behaviourist approach*, where competence is a 'description of an action, behaviour or outcome in a form that is capable of demonstration, observation and assessment' (McMullan *et al* 2003: 285) for example, rating scales. The second approach is the *generic approach*, where broad attributes are identified along with their underlying attributes such as critical thinking. These attributes are context free and there is the assumption that competence is transferable to other situations, although this has been refuted (Gonczi 1994). The third approach is the *holistic approach*. This approach includes the context of care and views competence as dynamic and evolving, and has been identified as a possible solution to criticisms of competence assessment. However, as less tangible attributes such as values and attitudes are included, the assessment of the holistic approach remains problematic. The problem with the holistic approach and the reason why the behaviouralist approach has won so much favour is that if the profession maintains that competence assessment

is the foundation of professional self regulation and is a means of ensuring standards and protecting the public, it is unacceptable to say it is too complex to measure.

When examining these three most frequent ways of assessing competence in practice it is clear that each on their own will not effectively evaluate all spheres of competence. In isolation these methods may not be useful measures of specific aspects of competence but further work needs to be done to evaluate a holistic approach to competence assessment rather than the development of local and poorly constructed instruments. A multifaceted approach to the assessment of clinical competence in nursing students involving self assessment, simulation, and assessment by mentors and colleagues is recommended by Norman *et al* (2000). There have been calls for the development of national (UK) competence assessment guidelines (Norman *et al* 2000) in order to achieve parity amongst graduates and post-registration students. This would allow development of a cohesive national research strategy to examine methods of assessment.

The regulation of assessment is a considerable problem in the UK. The evaluation of clinical assessors (Reeve, 1994) and clinical placements (Anderson *et al*, 1991) have been suggested to regulate the assessment process. A recent consideration is that of the external examiner and their role in clinical assessment (Jinks & Morrison 1997; Birchenall, 1994).

Walters *et al* (1995) see the external examiner system in medical education as a major guarantee that courses are of sufficient quality and that there is equality between courses both nationally and internationally. Others see the role of the traditional external examiners as outdated and involvement with clinical assessment outwith that role, and suggest that present nursing and midwifery needs more than the rubber stamping of academic components of courses (Birchenall, 1994).

Jinks and Morrison (1997) highlight the concern that if clinical assessment is to count in degree or diploma classifications it must be open to assessment by external examiners. They describe an attempt to involve an external examiner in assessment which they found was compounded by many problems and suggest that further research is required into the use of external examiners and the use of continuous assessment of practice.

Chambers *et al* (1996) suggest that a portfolio may be one way in which external examiners can be involved in clinical assessment. Students gather evidence to prove that they have achieved competence and present this to a panel of internal and external examiners. This, however, may be criticised as it is not a workplace evaluation and could be considered another theoretical assignment.

There has been reported criticism from students about assessment practices (Cudmore 1996). These reflect the concerns of educationalists and academics about subjectivity and the lack of validity and reliability of assessment tools. These concerns about clinical competence assessment have been compounded by negative attitudes to diploma students on clinical placements (May *et al* 1997). The concern of registered nurses about the clinical skills of students, compounded by the perceived subjectivity of assessment tools, has given students little faith in practice assessment. Wright (1997) reports that students feel poorly supported on placement and they often feel that they are used to fill in gaps in the service. This is supported by Coombes (1997) and Calman *et al* (2002) and several authors have taken note of the significant dropout rates from diploma courses (Richardson 1996; Coombes 1997; Cudmore 1996). Darbyshire *et al* (1990) also notes the problem of assessments on the ward, which are often rushed on the last day and do not seem to be a priority of clinical staff, as they can appear to them 'irrelevant and estranged from practice' (Darbyshire *et al* 1990: 73).

## CRITICISMS OF COMPETENCE BASED EDUCATION

Competence based education is in many ways appealing to the nursing profession. The development of explicit competencies against which one can evaluate the individual practitioner seems a solution to the problem of protecting the public and ensuring standards in professional regulation. However, the introduction of competence based assessment in nursing in the UK has not been without its critics. Much of that criticism in the 1990s was due to the uncertainty of the definition of nursing competencies although the competencies published in 2000 may have given clearer guidance at pre-registration level and registration.



One major issue for assessment of competence is that health care is very complex and nursing is a complex system within this. Complexity theory may help in explaining why assessment of competence is so difficult. Table 1 identifies the characteristics of simple, complicated and complex problems. If ‘nursing the patient’ is substituted for ‘raising a child’ it is possible to see that complex systems are difficult to evaluate. When working with individuals, knowledge and expertise are not enough and the outcome cannot be certain. Competence assessment is currently treated as a ‘complicated’ problem and not ‘complex’ and assumes that having experience and competence in one situation assures some certainty of outcome in a similar situation.

TABLE 1: SIMPLE, COMPLICATED AND COMPLEX PROBLEMS

SIMPLE	COMPLICATED	COMPLEX
<b>Following a Recipe</b>	<b>Sending a Rocket to the Moon</b>	<b>Raising a Child</b>
The recipe is essential	Formulae are critical and necessary	Formulae have a limited application
Recipes are tested to assure easy replication	Sending one rocket increases assurance that the next will be OK	Raising one child provides experience but no assurance of success with the next
No particular expertise is required. But cooking expertise increases success rate	High levels of expertise in a variety of fields are necessary for success	Expertise can contribute but is neither necessary nor sufficient to assure success
Recipes produce standardized products	Rockets are similar in critical ways	Every child is unique and must be understood as an individual
The best recipes give good results every time	There is a high degree of certainty of outcome	Uncertainty of outcome remains

Source: (Glouberman and Zimmernan 2002:2)

To some extent assessment of technical competence can be deemed ‘complicated’ or ‘simple’ and assessment instruments such as rating scales do have success in the evaluation of practitioners’ practical skill in the clinical situation. Success could be predicted as criteria could be identified and these would be transferable to other situations. As every encounter with a patient is different it is more difficult to measure and predict success or quality.

Runciman (1990) suggests that for competence based education to work, clear definitions and precise statements of competence must be developed. Runciman has



reservations about the consequence of writing these precise statements in the context of a practice discipline. It may not be desirable or appropriate to break down nursing into a list of observed behaviours, and competence should not equate with a finite behavioural objective. Benner (1982) also considers that there are some limitations to competence based assessment, as it could result in a reductionist view of nursing. The development of competence can be considered a social process, emphasising that nursing competence is more than learning and performing skills. However, as the focus on practical and technical skill that was a feature of 'traditional' (pre-diploma programme) nurse education has changed to a more theoretical approach (Bjork 1999), resulting in 'vague and unclear definitions of nursing competency' (Bjork 1999:34), the view has been put forward that there may be something positive in the re-focusing of skills, as skill acquisition seems to be a concern for students on the diploma courses (Bradshaw 1997).

Skill acquisition has been identified by the profession as an area for concern for both employers of newly qualified nurses (Runciman *et al* 1999) and for educationalists (Elkan & Robinson 1995; Dolan 2003; Bjork 1999), although this only serves to highlight the differing needs of the educational establishment and service. The universities wish to produce graduates that are able to continue life long learning whereas service (employers) wish even new graduates to be able to enter the employment market with minimal need for supervision and education (Chapman 1999).

The use of National Vocational Qualifications (NVQs) in England and Scottish Vocational Qualifications in Scotland (SVQ) within nurse education (for example as a route to the completion of the Common Foundation Programme) is examined by Milligan (1998). He concludes that the unnecessary emphasis on performance rather than the ability to transfer skills to differing situations means this type of education is incompatible with any attempt to educate nurses or midwives. Too much emphasis is placed on outcomes and not enough on the critical thinking.

#### COMPETENCE ASSESSMENT IN HIGHER EDUCATION

The focus on vocational skills and service is to some extent driving the pre-registration curriculum and there are questions as to whether this is compatible with the values of

higher education. One of the purposes of moving nursing into higher education was to move away from the traditional focus on apprenticeship and training for an occupation. There are some concerns that competence based education has not allowed nursing to move from these simplistic goals, and is still promoting the idea that competence is concerned with 'what people can do rather than what they know' (While 1994: 526). There is some concern that competence based education is driving nursing in the direction of a focus on psychomotor skill and not some of the other 'humanistic' skills of the nurse. This is a phenomenon that is not just apparent in the UK but also in the US and Australia (Chapman 1999). It has increasingly been an issue at post-registration level with the development of advanced practice roles, some of which have a focus on performing tasks rather than holistic care (McGee *et al* 1996). One of the reasons that this may be the case is that competencies in areas other than knowledge and observable technical skill are difficult to identify and more difficult to assess:

'Rather than nurture natural abilities such as curiosity and creativity, it is easier to value competencies that can be produced, reproduced, assessed, and measured according to plan, in a quest for bigger and better results. That is to say, it is easier to value and measure competencies that demonstrate what people can do repeatedly, rather than during particular and unique encounters' (Chapman 1999:132).

There are both practical and ethical issues surrounding the observing and assessment of the humanistic and interpersonal aspects of nursing. The interpersonal relationship between a nurse and patients may be hindered by the presence of a third party assessor and patients may not consent to another person being party to certain encounters. This may mean that interpersonal skills may be assessed in superficial and routine situations such as during admission procedures or whilst undertaking technical procedures rather than in genuine situations of the therapeutic relationship at work. This may be more apparent in areas of nursing where the therapeutic use of self is at the forefront of nursing care, such as mental health or learning disability nursing. This has led to the teaching and assessment of interpersonal skills in simulated situations. The criticism of this type of assessment was highlighted earlier.

The movement of nurse and midwifery education into higher education has not been smooth and there are problems with the integration of nursing courses and students

(Elkan & Robinson, 1995). There has also been some concern that competence based courses and competence assessment do not fit with the higher education system in the UK. Edwards and Knight (1995) suggest that competence assessment cannot simply be added to existing courses and that it has to be placed in the context of the education system and of continuing professional development. Competence based assessment, in their view, may appear so problematic to educators that they will prefer to remain with tried and tested assessment techniques.

Traditional assessment techniques in higher education include examinations and course papers. Although these demonstrate the knowledge a student has of a subject, they do not give prospective employers any idea of which skills a student possesses. Girot (1993) identifies that, within nursing education, tools to assess competence in the cognitive domain are more extensively developed than those in the affective or psychomotor domains.

Although Edwards and Knight (1995) recognise that there are many problems with the introduction of competence assessment (cost, staff time, staff development implications and the impact of competency assessment on degree classifications) the positive claims of a competence based education are considered: a wider range of attainments; qualities employers value; flexible curricula and learning and assessment often in real life settings. It is claimed that these are not at odds with a traditional liberal education and they are 'implicit in the notion of an educated person' (Edwards and Knight 1995: 16). Mathias (1998) also considers that there are many advantages to competence based education primarily because it brings education closer to work.

Edwards and Knight (1995) attempt to take some steps towards the integration of competence based assessment in higher education. They do however take a skills based approach and do not seem to address the issue of how the more complex aspects of competence can be assessed, for example attitude, intuition and empathy. These seem to be recurring key issues in assessment competence in nursing and midwifery.

Competence assessment is currently undertaken in the clinical setting. This assessment is based on observation and is considered inherently subjective (Ross *et al* 1988).

Consistency is eliminated by the changing condition of the patient and the environment and comparable experiences for different students are thus made impossible. Students are also in the position that they are assessed while they are still learning, often leading students to be judged by the standards of the individual clinician who has the dual role of teaching and assessing (White *et al* 1993).

Diploma course students experience and learn in the clinical areas in a different way to traditionally trained nurses and there is concern amongst students that this is not recognised amongst clinical staff. Assessment tools for the diploma students may be very different to those which the assessors experienced and therefore it will be necessary for these practitioners to have some introduction to the rationale for assessment tools (Philips *et al*, 1994). Phillips *et al* (1994) also address the issue of who actually completes the assessments; competent practitioners do not always make competent assessors. They suggest that clinical staff should have some kind of input into the development of the tools.

White *et al* (1993) suggest that, although courses focus on general skills, students are being taught in a task centred way that is not relevant to student outcomes, and there are few links made between theory and practice. Bradshaw (1997) considers that the design of current assessment tools often means staff have to make their own judgement of a student's competence. There have been some concerns about the preparation of clinicians taking on the role of mentor/assessor (May *et al*, 1997) and about the structure and quality of practice placements for students (Elkan & Robinson, 1995).

## THE QUEST FOR OBJECTIVITY

The two main quests of educationalists seem to be overcoming the perceived subjectivity of assessment and ensuring that the search for validity and reliability is paramount. Within the medical literature, particularly in surgery, the focus is on objective measurement of technical skill, whilst acknowledging the importance of other skills such as effective communication, (Crossley *et al* 2002; Darzi and Mackay 2001; Moorthy *et al* 2003) and most effort in researching the assessment of competence has

gone into this task. However, if nursing competence is about knowledge, skills, values and attitudes, what is not clear is whether all of these domains of nursing competence can be assessed objectively.

For example, both defining and assessing concepts like caring and empathy are difficult tasks. Webb (1996) identified from a review of the literature more than thirty words that are linked with 'care'. Caring is considered an elusive concept (McFarlane 1988) and there are a number of different conceptualisations of care in nursing (Horsburgh 2001, Kyle 1995). The majority of research on caring has been quantitative in nature, where specific behaviours are identified (to facilitate measurement) that communicate caring (Kyle 1995). When attempts are made to determine the attributes of caring and to try to measure them, much criticism is made of this as it is deemed too difficult to capture all aspects of caring in a behavioural checklist, and there have even been suggestions that quantifying caring has impeded research on the subject (Paley 2001). This dichotomy of approaches, paralleled in the research approach (quantitative or qualitative), to the field of caring is identified by Lea and Watson (1996), and it is this debate that seems to take up more 'column inches' than research itself. So whilst competence is difficult to define, so are many of the concepts related to it., This may be why the focus of competence research has been on the observable and measurable rather than some of the less tangible aspects of nursing practice.

Two research papers examine the pursuit of objectivity in clinical assessment tools in medical education. In the first, Van der Leuten *et al* (1991) explore subjectivity and its effect on reliability. They identify two ways of describing objectivity: firstly, objectivity as a goal of measurement and secondly, objectivity as a set of strategies designed to reduce measurement errors which they term as 'objectification'. By examining papers from medical literature they come to the conclusion that reliability, i.e. the reproducibility of assessment scores, is not affected by the subjectivity of the assessment. They conclude that "the assumption of automatic superiority of objectified measures finds no support from the studies reported in this paper" (Van der Leuten *et al*

1991: 117) and that the choice of which assessment tools are used would be better judged by appropriateness to the educational situation in which they are used.

In the second paper in this series, Norman *et al* (1991) consider the alleged advantages of objectification to be validity, fairness, efficiency and transparency, although they give a warning over the interpretation of correlational studies they use to make conclusions. Objectified tests were considered more efficient when large numbers of students were involved. Some studies were considered valid and fair by staff and students and the authors warn that strategic behaviour of students in preparation for the assignment may affect this. Empirical evidence also suggests that information gained from objectified tests was no different to that of more subjective tests and content validity could be lost by overemphasis on rote memorising for objectified tests.

Norman *et al* (1991) confirm that objectified assessments may be preferable to use in some situations but they cannot be judged as superior to more subjective methods for that reason only. Assessments would have to be appropriate to the environment and resources available, and appropriate to the stage of the students. The authors consider that objectified assessments were more appropriate to students in the earlier stages of their course when rote learning might be more acceptable.

One question is whether assessment is ever objective. Studies which evaluate validity and reliability of competence assessment instruments are few and far between in nursing (Watson *et al* 2002a), notable examples being Norman *et al* (2000), Bartlett *et al* (1998) and Meretoja *et al* (2004). More often there is a focus on qualitative evaluation of satisfaction or with implementation (Dolan 2003) of assessment instruments. When validity and reliability of competence assessment instruments *are* evaluated, it is inter-rater reliability that seems to be the most difficult aspect to confirm. This is supported by recent research from the nursing literature (O'Conner *et al* 2001; Fisher and Parolin 2000). This may be because:



‘Values are intrinsic in all human encounters and in the evaluation of these encounters. Evaluation in education is actually describing value judgements in presumably objective measurement terms and translating those data into a grade’ (Curl and Koerner 1991:23).

This view leads Chapman (1999) to ask the question: ‘is anyone other than the client able to truly judge the outcome of therapeutic interactions?’ (Chapman 1999 p133), which highlights the importance of the study reported in this thesis. Crossley *et al* (2002) suggest some strategies that may help to reduce threats to reliability, for example by the training of assessors and the development of clear assessment criteria.

There is the suggestion then that all evaluation whether seemingly objective or not is in fact highly subjective as it depends on the background and values of the assessor. This is something that makes the assessment of clinical practice so difficult. This does seem to be borne out in student views of the assessment procedure: ‘fitting in’ to get a good assessment was of significant importance in practice placements (Calman *et al* 2002; Melia 1987; Horsburgh 2001). It is interesting to note that when nurses were approached in order to negotiate access to patients for this study, a number of comments were made that emphasised that patient assessment of nursing care would be too subjective to be useful. This indicates that although nurses’ assessments of other nurses are considered to be subjective, this is in some way less subjective than patients’ views. This may possibly be due to the perceived inside knowledge of nurses - at least a nurse’s subjectivity has a basis in professional nursing knowledge.

## ASSESSING LEVELS OF PRACTICE

Much of the literature cited focuses on the assessment of competence in pre-registration nursing, but there are moves to develop competency based frameworks for the assessment of registered practitioners. Although a national framework of competencies has been developed for the UK for undergraduate nursing programmes, there is currently no equivalent for registered or advanced practice nursing. Defining, and assessing, different levels of practice is a challenge that nursing now faces. Within medicine, with



changes in legislation for re-registration and training of pre-registration house officers, advanced level competence is assessed.

The lack of clarity in the definition and role of advanced practice nurses makes assessment of advanced practice nurses in the UK a difficult task. Competencies for nurse practitioners developed by the Royal College of Nursing (RCN) are the closest that the UK has to a common understanding of the role of the nurse practitioner (Royal College of Nursing 2002), although this is not recognised in any legislation or regulation.

Even at pre-registration level in nursing, with entry to the register via degree and diploma route, there is concern regarding the definition of diploma or degree practice (Elkan and Robinson 1995; Wilson-Barnett *et al* 1995). White *et al* (1993) found diploma level practice to be poorly understood by academic and clinical staff and students. While *et al* (1998) undertook a comparative study of outcomes of pre-registration nurse education programmes. Although drawing some interesting conclusions, outcomes were assessed and not level of practice. There does not appear to be any clear definition of what diploma or degree level practice is and what distinguishes one from the other.

## **The role of practice assessors**

Clinical assessment is normally carried out during practice placements. Chambers *et al* (1996) consider this to be 'authentic' evaluation, i.e. evaluation that occurs within the real work situations. Although there have been criticisms of the subjective nature of this type of assessment (Ross *et al* 1998), it does have the advantage of seeing students in the changeable ward environment. Clinically based assessments eliminate the concern about students' abilities to transfer skills from a lab based assessment to practice areas. However, there seems to be little published on the subject of who should be responsible for and who would be best at the teaching and assessment of students in the clinical areas.

It is workplace supervisors, the mentor or preceptor in nursing, who are most often considered the appropriate people to assess practice based learning, as they have most knowledge about best practice in the work setting and they are likely to have the most significant amount of contact with the student (Toohey *et al* 1996). However, this model has its drawbacks as it has been suggested that the dual role of assessment and supervision, which may involve a significant amount of pastoral care for the student, can be incompatible (Gilmore 1999; Wood 1986).

Clinical staff who have undergone some course of preparation are currently involved in assessment of students nurses in the practice situation, but recent research has indicated that due to the shortage of mentors, clinical assessors do not all undergo mentorship and assessment training (because of annual leave or sickness or because of the shortage of permanent staff) (Calman *et al* 2002). It is well documented (May *et al* 1997; Elkan & Robinson 1995; White *et al* 1993) that practice assessors felt and were poorly prepared for their role in teaching and assessing diploma students. Practice assessors are reluctant to assess practice negatively (Norman *et al* 2000; Wood 1986; Watson and Harris 1999; Duffy 2004) and this phenomenon is present in other disciplines, for example, teaching education (Briggs 1984). Watson and Harris (1999) identified that 46% of mentors agreed with the suggestion that students were allowed to pass their placement despite their performance being unsatisfactory.

White *et al* (1993) found that academic staff in nursing played an insignificant role in clinical assessment (apart from in the OSCE or simulated situations which tend to be facilitated by the educational institution rather than the clinical setting), as well as in clinical teaching, and saw their role as mainly supportive (Elkan and Robinson, 1995). Clifford (1994) sees one of the key problems in nurse tutors setting the parameters of clinical assessment but not fully participating in practice, leaving them without a clearly defined role. Although many reasons are given for this such as constraints on time and tutors focusing on improving their academic credibility, Elkan and Robinson (1995) do consider that the continued lack of responsibility for clinical teaching and assessing by academics is one of the failings of diploma courses. This somehow suggests that

academics' assessments of students would be valuable in the clinical setting, but it is not clear why this would be the case particularly when the clinical credibility of many nurse lecturers is questioned (Goorapah, 1997). This may be an example of the divide in what is taught and expected in an academic department and the skills that students really need in the clinical situation as noted by Melia (1987) and still seen as a concern with diploma courses (Elkan and Robinson 1995). However, it is reported by students themselves that they would welcome greater involvement by academic staff as this assessment would be seen as more objective (Norman *et al* 2000).

## **Patients' views of nursing**

There are numerous policy documents indicating the importance of patient involvement in the design, implementation and assessment of health services (Scottish Executive 2002, 2003; Department of Health 1997, 1998, 2000, 2001a). Patient involvement in the assessment of service is highlighted to some extent in patient satisfaction and experience literature, which is summarised below.

### **IMPORTANT NURSING/CARING BEHAVIOURS**

Knowing what aspects of nursing care are important to all stakeholders is key to the understanding of nursing. There is extensive interest in this area and a wide variety of empirical evidence is available. Various methods have been utilised in these studies: firstly, quantitative, using scales and questionnaires, examples of which include White (1972), Keane *et al* (1987) and Wildmark-Petersson *et al* (1996); and secondly, qualitative, phenomenological and grounded theory studies using in depth interviews, examples of which include Halldorsdottir and Hamrin (1997), Haggman-Laitila and Astedt-Kirki (1994) and Von Essen *et al* (1995).

One of the most significant developments in quantitative measurement of important nursing skills was the development of the Care-Q instrument. This instrument was developed in the United States of America (USA) in the late 1970s and early 1980s. Patients and nurses were involved in the development of this instrument, which

identified key nursing skills. This suggests that this instrument has content validity in determining the most important aspects of nursing care. Q-methodology is utilised with this instrument, a technique that centres on the sorting of cards (Q sorts), in this case with selected nursing skills written on them, and in the statistical correlation of the ranking of these cards between individuals (Kerlinger 1986). Kerlinger (1986) identifies that this method does have strengths and limitations, but concludes that it is a useful tool for the social researcher.

In the initial study and development of the instrument by Larson (1981), it was determined that the most important aspects of nursing care for patients are practical skills and for nurses psychosocial skills. Several replication studies have been undertaken and these also suggest that cross-culturally and in several different care settings the findings are similar (Bjork 1995). A review of the literature did not, however, identify a replication study in the UK.

Patistea and Siamanta (1999) offer a critique of research relating to patients' views compared with nurses' views of caring. During this review they identify particular issues about the research methods commonly utilised in research on caring. They are particularly concerned with the use of quantitative methods due to the complexity of the subject. Patistea and Siamanta (1999) doubt whether a fixed instrument would be able to measure such a multi-faceted concept. Sample sizes in these quantitative studies have been criticised for being too small, making the results less robust. However, although somewhat complex for the participants to complete, the Care-Q method does produce consistent results, which suggests its validity and reliability (Patistea and Siamanta 1999).

Even though a wide variety of approaches and methods have been utilised over time, this research spans back to the early 1970s (White 1972). The evidence strongly suggests that whilst patients identify technical skills and nursing knowledge as being important aspects of nursing care, nurses, irrespective of clinical speciality, tend to focus on the psychosocial aspects of nursing (Patistea and Siamanta 1999). Greenhalgh *et al* (1998)

indicate that gender is the greatest influence on which aspects of caring are valued by nurses.

Wichowski *et al* (2003) report the findings of a study to rank quality nursing activities. There was a significant difference reported in the importance of psychosocial activities between patients and nurses, with patients ranking psychosocial activities lower than nurses. This may be because of the items chosen to represent psychosocial activities and because all of the activities in the questionnaire were validated by nurses and not patients. Activities included pet therapy and music therapy, counselling and reminiscence; in contrast, physical activities included resuscitation, wound care and intravenous therapy. Bearing in mind that the sample of patients was from medical and surgical areas this list of psychosocial activities does not seem to have content validity, although as this study was conducted in the USA, it may reflect cultural differences.

One study utilising qualitative methodology that is of particular note is work undertaken by Haldorsdottir and Hamrin (1997). This study confirms that patients, when asked about this nursing, care place practical skill and professional knowledge as being the foundation of all nursing practice. Their study was founded in phenomenology and the focus was on cancer patients' perspectives on caring and uncaring encounters with nursing staff. This was a very small study of nine patients in Iceland and generalisation from the study, due to sample size and representativeness and cultural differences, is difficult, however, as the findings of this study are supported by the quantitative data cited above they add an important element to the discussion as the context for ranking important behaviours is illustrated in participants comments This study is also of note as in the assisted theoretical development of this study and will be further discussed in later chapters. Being theoretically and technically competent was identified as essential to the nursing encounter,

‘caring without competence was in most cases meaningless for them [the patients]’.  
Haldorsdottir and Hamrin (1997:122).

This study allowed Haldorsdottir (1997) to further develop a theory of the duality of caring and competence, concepts that most nurse theorist divide (Haldorsdottir 1997).

This model of professional caring 'competence administered with compassion' (Haldorsdottir 1997: 116) includes capability in knowledge and skill as well as the human skill to relate to the person in an honest, individual and empathic way.

The evidence suggests that patients themselves consider that primary importance should be given to practical nursing skills. These skills, in the view of patients, take priority over what could be termed the emotional and interpersonal aspects of care. This is in contrast to professionals who indicate that psychosocial care is most important.

### GOOD NURSING

The literature would suggest that the concept of 'good nursing' goes beyond competent, safe and effective practice, and seems to incorporate wider features such as environment, individualised care and *quality* of interpersonal relationships. However, there appears to be only a limited literature base available on this topic. In contrast to the paucity of literature regarding good nursing, a significant amount of literature is available related to the question of the attributes of a good nurse, for example Evans (1991) and Masson (1990). These papers were focused on the personality characteristics of a good nurse such as morality (Alavi and Cattoni 1995).

Three particular papers (Astedt-Kirki and Haggman-Laitila 1992; Radwin 2000; Davis *et al* 1990) suggest empirical evidence for the understanding of good nursing. Astedt-Kirki and Haggman-Laitila (1992) embarked on a research project in Finland in order to identify what users of services considered as good nursing. One hundred qualitative interviews were undertaken with patients/clients in hospital and community care. The key themes that emerged from this data were the personal characteristics of a nurse, such as kindness, knowledge and friendliness, as well as how individuality of care and safety are maintained. This was significantly enhanced if the nurse had involved the patient in their care. Feeling comfortable in hospital was an element of hospital care that was related to good nursing. This included the physical environment and noise levels. A further important aspect of this category that should be noted is patient waiting times in hospital clinics and at community practices.



The results of this study were consistent with research that was undertaken in the USA using grounded theory, in which cancer patients were asked about their perceptions of quality nursing care (Radwin 2000). Using purposeful sampling, twenty-two patients were interviewed. Findings identified eight characteristics of excellent nursing care:

- Professional knowledge - nurses who 'knew what they were doing' (Radwin 2000: 183). Technical competence was considered to be one aspect of this attribute.
- Continuity- having repeated encounters with one nurse. This was firmly linked with the idea of trust in the nurse-patient relationship.
- Attentiveness. This related to both listening to the patient's needs and attending to these promptly.
- Co-ordinating care and associated teamwork. Nurses were seen as important in ensuring seamless care. An example of this was passing on relevant information about patient care.
- Partnership between patients and clients.
- Individualisation of care.
- Rapport with nurses. This included nurses sharing some personal information in order for patients to feel they had developed a bond with nurses.
- Caring. Patients described this as nurses showing concern for patients, giving support through difficult times and being remembered by nursing staff.

The empirical evidence suggesting what the profession considers to be good nursing is also limited. The one existing study identified (Davis *et al* 1990) focuses on what student nurses in China consider to be descriptions of a good nurse, and incorporated nursing behaviours (good nursing). All thirty-three students from a single cohort of students completed the questionnaire. In addition, an open-ended question asked students to identify characteristics of good nursing. The two personal characteristics



identified by the highest number of students were kindness and good character. The behaviours that were considered important were skill in nursing techniques, swiftness and being willing to help. The knowledge that was considered essential was specific nursing knowledge.

It is clear from the summaries of these three research reports that they can be by no means considered as representative of all patients' and all nurses' views. This scant evidence does at least provide an idea of good nursing. There may be some strength in the fact that similar findings were found in these three diverse groups of research participants. Results may be considered relevant as they are from wide-ranging groups and cross-cultural.

It could be suggested, on the basis of available evidence, that good nursing may be conceptualised as encompassing technical competence, but also including a wider range of nursing skills. The further attributes that turn competence (safe and effective nursing care) into good nursing include involvement of patients in care, kindness and individuality of care. This is usefully summarised by Fosbinder (1994) as 'going the extra mile' (Fosbinder 1994: 1087). Competence may be considered a necessary precursor to good nursing care, but does not in itself achieve this.

## PATIENT SATISFACTION

Patient satisfaction is now an established indicator of the quality of care (Mahon, 1996) and is one desired outcome of health care (Williams 1994). Measurement of patients' satisfaction is the most utilized method of integrating patients' views into the health care system despite the lack of sound theoretical underpinning, the lack of gold standard for its measurement (Edwards and Staniszewska 2000; Attree 2001) and the methodological criticisms summarised by Williams (1994) and Williams *et al* (1998). They have two main criticisms. Firstly, that patient satisfaction as measured by surveys make patients express themselves in ways that they would not usually and cannot take note of the complex beliefs patients have about health and health care (Williams 1994). Secondly, that surveys report high satisfaction levels even though negative experiences have

occurred. Patients have a complex way of translating experience into expressions of satisfaction and this, it is suggested, is related to the perceived culpability of the service for the negative experience (Williams *et al* 1998; Edwards *et al* 2004).

An increase in interest in patient satisfaction seems to have stemmed from the belief that it would improve compliance, consumerism and the evaluation of care. Williams (1994) suggests that patient satisfaction has been embraced by the medical professions as a method of improving client concordance with care, as satisfaction is deemed to improve compliance. Furthermore, it has been associated with the increase in consumerism in health care and has also been linked with the increasing importance of evaluating public services (Williams, 1994). Mahon (1996) analyses the concept of patient satisfaction as it relates to nursing care. Patient satisfaction is identified as being important to nursing as it is more effective in capturing the quality of care than the more traditional measures such as mortality and morbidity (Mahon, 1996).

Patient satisfaction, as with other terms identified in this literature review, is difficult to define (Mahon, 1996). Williams (1994) suggests that patient satisfaction is multi-dimensional in nature and Thompson and Sunol (1995) consider it to be closely related to the issue of patient expectations. Bond and Thomas (1992) suggest that individual research studies conceptualise patient satisfaction differently, thus making comparison of these difficult. Indeed these studies do often present divergent findings. Bond and Thomas (1992) continue by criticising the quality of much patient satisfaction research in nursing. However, they do acknowledge the methodological difficulties that are associated with its measurement, for example, when, where and how patients are asked to assess their satisfaction with care. French (1981) suggests that interviews are preferable to self-completion questionnaires in eliciting this information, although a self-completion questionnaire could be utilised if carefully developed. Edwards and Staniszewska (2000) also suggest caution when using quantitative measures of patient satisfaction and suggest more user-led qualitative approaches to patient views of service, providing methods are rigorous and have a theoretical underpinning. Wilde *et al* (1993) indicate that the majority of studies looking at patients' perception of care are

undertaken using predetermined attributes and these are generally not grounded in models based on patients' understanding of an area. This is supported by Edwards and Staniszewska (2000) review of the literature. Walsh and Walsh (1999) contend that patient satisfaction scales often do not isolate specific satisfaction with nursing care and that scales tend to produce consistently high scores for satisfaction, questioning their discriminatory ability.

As with the concept of good nursing, patient satisfaction is related to a broad spectrum of nursing skills, technical competence being only one of these (Mahon, 1996). Thompson and Sunol (1995) following a review of the literature suggest that there is in fact only a weak relationship between professionals' technical competence and patient satisfaction. What is not clear, however, is whether the tools that were utilised to measure patient satisfaction were adequately able to construct the competence of professionals in a manner that patients could understand and assess.

## QUALITY OF NURSING CARE

Patient assessment of quality has been primarily undertaken by the use of measurement instruments (Norman and Redfern, 1993). These use pre-determined attributes of nursing, often generic in their nature, which may not give specific feedback on specific aspects of care. These criteria are generally developed from the perspective of professionals rather than from that of patients (Redfern and Norman, 1999a). Norman and Redfern (1993) indicate that these assessments may often be undertaken by external assessors, and that the validity and reliability of these measures may be tenuous.

Since the early 1990s, some attempt has been made to conceptualise quality of care using qualitative techniques. Williams (1998) undertook a qualitative study of nurses to identify their perceptions of quality of care. She noted that 'significant variations exist in its interpretation and use' (Williams 1998: 808). She determined that quality for these nurses could be expressed as 'meeting all the needs of the patients and clients you're looking after' (Williams 1998: 810). These needs were identified as being physical or psychosocial, although extra or additional needs such as the personal touch were

identified. For these extra needs an approach where ‘nothing was too much trouble’ (Williams 1998: 810) had to be utilised. The nurse’s own time or resources may be required for this extra care provision.

One study in particular has sought to seek patients’ views directly as to what they consider to be quality of care. Wilde *et al* (1994) describe their development of a model of quality of care from a patient’s perspective. This model suggests that patients’ ideas about quality of care are formed by experience of an ‘existing care structure’ (Wilde *et al* 1994: 40) and by their own personal experiences and expectations. Therefore it incorporated both patient satisfaction and expectations of care. The different elements can be used to develop a complete picture and this complete picture can be seen as relating to two dimensions that are identified as ‘the resource structure of the care organisation’ and ‘the patient’s preferences’.

Wilde *et al* (1994) utilised a grounded theory approach to develop this framework. A quantitative instrument was derived from this data which was designed to measure:

‘the distribution of the different attitudes ... across different patient populations and care contexts’ (Wilde *et al* 1994 p39).

It was identified that patients’ perceptions of quality of care can be examined from four dimensions:

- Medical-technical competence is related to person-related qualities of the care organisation and includes having qualified and proficient staff available.
- Physical-technical conditions relate to the care organisation and its ability to provide the physical and technical conditions to care for the patient.
- The identity-orientated approach is when there is a focus on the desire for care to be delivered by an individual whose qualities include knowledge and empathy and is able to see the patient as an individual.
- The socio-cultural atmosphere is characterised by the patient’s wish for a humane and friendly care environment that is as like a home environment as possible.

This framework has been compared with models that have been reported in the literature. All of these four dimensions are identified elsewhere in the literature (Ware and Snyder 1975; Donabedian 1980; Merterko and Rubin 1990). However, Wilde *et al* (1994) do not consider that these authors emphasise the socio-cultural aspect of care as strongly as their own framework and suggest that they have not related dimensions developed to a conceptual framework.

Redfern and Norman (1999 a and b) utilise the critical incident technique to generate indicators of quality. These indicators, views of quality of care, were compared between nurses and patients. Redfern and Norman's research indicates that there is similarity in quality of care indicators subscribed to positive and negative categories. Their findings differ from other evidence that suggests that patients' and nurses' views are not congruent, for example Iruita (1996).

Redfern and Norman (1999 a and b) suggest that the top three positive categories and the top five negative categories were the same for both groups. There was some divergence in opinion in the lower ranked indicators in both the positive and negative categories. Important indicators for quality of nursing care were '...psychosocial, therapeutic and thorough care.' (Redfern and Norman 1999b: 419). Many of the indicators of quality such as individualised care, having time for patients and ward atmosphere and environment are very similar to expressions of good nursing indicated in empirical research findings, for example Astedt-Kirki and Haggman-Laitila (1992) and Iruita (1996).

Professional views, when expressed in quantitative measures such as 'off the peg' quality assurance instruments, do not necessarily incorporate all aspects of quality. However, qualitative evidence does seem to suggest that, at least for the most essential aspects of quality of nursing care, there is evidence of some agreement between patients and nurses. However, these qualitative studies do focus on quality of care in the hospital setting and therefore the evidence is still limited in this area.

Using a grounded theory approach, Attree (2001) examines patients' and relatives' perspectives of quality of care and identifies key criteria used to evaluate their

perceptions of quality of care. Good quality care is conceptualized as individualised, patient focused and related to patients' needs and it included involvement in decision making with help offered willingly.

This research further indicates that if patients are asked about quality of care they focus on interpersonal skills, but if they are asked to identify important behaviours they focus on technical skill. It would seem that this is not contradictory but rather that patients are responding to different questions. It also does not mean that technical skill is not important in quality of care but when patients have 'free rein' over responses they focus on the quality measures that are most important to them: the quality of the nursing encounter.

## **Patient assessment of competence**

There is a growing body of literature supporting patient involvement in nurse education (Rudman, 1996) and in the teaching of student nurses (Wood and Wilson-Barnett, 1999). This involvement of users in nurse education is not new (Forrest *et al* 1998). It has, however, been implemented in a non-formalised way with patients telling of their experiences and reflections. Forrest *et al* (1998) suggest that although this may give meaningful educational experiences at one level, formalising these in the curriculum to give them more status as educational experiences is more problematic. The English National Board for Nursing, Midwifery and Health Visiting (English National Board 1996) in its document 'Learning from Each Other' suggest that a radical approach is needed that involves shifting control and power in all aspects of education.

Some of the issues relating to the mental health user involvement in nurse education are explored by Forrest *et al* (2000). This research was funded by the National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS) and involved users and student nurses in the research. Although their method may be criticised as users, drawn from particular user groups, may not be representative of the wider user population, it takes a meaningful step in involving users in a formal way in curriculum development. Forrest *et al* (2000) suggest that, by involving users, students' understanding of their



experience can be enhanced. It also allows service users to share their perspective of care and become involved in the defining of what they need from services. Risk *et al* (2000) draw three main conclusions from this same empirical research. Firstly, the issues around involving users in education are complex. Secondly, a strategic and coherent approach is required to ensure the involvement is not merely tokenism in education programmes. Thirdly, and possibly most contentiously, they suggest that users involved in education programmes cannot be seen as equal partners until they are remunerated financially in the same way as nurse educationalists. Other suggestions are that students should not just be exposed to users' and carers' formal input throughout the curriculum but that future development should also include user participation in recruitment and assessment of students.

The focus of this particular study is the competence to practise of nurses. Although competence is extensively debated in the professional literature, there seems to be little in the way of discussion of patients' views. Patients' views have been elicited extensively in a number of related areas, such as good nursing and satisfaction, as summarised above. There is an assumption that it is a positive move to involve service users in the assessment of competence (Norman *et al* 2002; Cescutti-Butler and Galvin 2003) but there is very little evidence to suggest that patients can or indeed want to assess the practice of nurses. Thompson and Sunol (1995) suggest, following a review of the literature, that there is only a weak relationship between professionals' technical competence and patient satisfaction and this may be one reason that research into patients' views of competence has not been explored to a greater degree.

Where assessment of students by patients has been implemented is in simulation exercises. These exercises are often utilised during objective structured clinical examinations (OSCE) and the use of simulated patients can be seen most frequently in medical education. There are some institutions that do utilise 'real' patients (rather than staff or students acting as patients) for examination purposes and after a period of training these patients may be involved in the assessment of students (Pololi, 1995). Wykurz and Kelly (2002) report the finding of a literature review on the role of patients



as teachers in medical education. Of the 23 papers included in their review, nineteen referred to patients as assessors. This assessment was primarily in simulated situations in the learning of specific clinical skills.

There have also been developments in the incorporation of user assessment in social work education (Levin 2004). This guide to involving service users and carers in social work education is published by the Social Care Institute for Excellence (SCIE) (Levin 2004) and provides resource information for the development of user involvement in education. This document emphasises the importance of education and training for users as well as their reimbursement at the same rate as other educators. Some instances of user assessment of students are highlighted, but these seem to be associated with academic work, and consist of presentations or videos of simulated encounters with users rather than assessment with the real world of practice. A survey of practice teachers' experiences of user involvement with student assessment on placement is summarised. Although only twenty responses were received, some of the key findings are interesting. Firstly, patients' assessments should not be based on national competency guidelines but users should evaluate from their own perspective, but:

‘that practice assessors should the translate this feedback into evidence for core competencies/national occupational standards [and that] users should not be expected to identify aspects of the student’s performance that need to be developed, that again is the practice teacher’s task’ (Levin 2004: 42)

These statements do seem to be contradictory, asking patients for their perspective, fitting this into professional views and then suggesting that patients should not identify areas of development for students. It is also not clear what weight is given to this assessment, but it is referred to as user feedback rather than assessment which suggests it to be less formal and weighty than professional assessment.

In eliciting views on the quality of nursing, some findings are reported about patients' assessment of nursing competence which indicates that patients are able to judge technical competence (Wilde *et al* 1994). There is, as yet, no available literature on how patients construct or conceptualise the competence of those nursing them. Haldorsdottir's (1997) and Haldorsdottir and Hamrin's (1997) work as cited above does

identify that competence in skills and knowledge is important to patients, but does not suggest that patients can either identify what those specific skills are or whether patients feel able to assess them. Despite this, institutions in the UK are already involving patients in the assessment of nursing students (Spence, personal communication 2004) and in medical revalidation (Royal College of Obstetricians and Gynaecologists 2002).

Cerscutti-Butler and Galvin (2003) report the findings of one of the very few studies that examine nurses' competence from the perspective of the user, in this case the parents of children in the neonatal intensive care unit (NICU). Although the authors use a grounded theory approach to the study, this work is not as useful as it might be as the categories reported are more descriptive than conceptual. This provides an interesting insight into user views of nursing competence but does not generate theory or highlight the conceptual importance of these categories. However, as this is one of a very few studies examining competence from the user perspective it is worth summarising the results.

Integration into the unit as a category highlights the difficulty of becoming a parent in the NICU and fitting into ward routine. Parents value staff and the care they give, but feel useless in the care of their own child. This category also highlights the expectation that parents will learn about their baby's condition and the technology and equipment that is keeping their baby alive. Control was also identified as a category. Parents felt that they did not have control over the situation which was exacerbated by staff having control over access to the baby. Parents expressed a tension between being relieved to hand over care to staff and wanting to be equal partners in decision making. The category that describes parents' perceptions of competence identifies that parents 'do not link their perceptions of competence to tasks or procedures' (Cerscutti-Butler and Galvin 2003: 758). This seemed to be partly due to the fact that parents were asked to (and in fact preferred to) leave when a procedure was performed on their baby and also because parents describe competency as a caring attribute, which they express in a number of ways, for example: 'being genuinely concerned about you', being 'sympathetic towards me' and 'they were sort of friendly' (Cerscutti-Butler and Galvin 2003: 758). In the

category of caring and communication, parents expressed the view that caring was closely linked to the quality of communication.

The analysis in the following chapters also highlights some of these issues, but will suggest that hospital patients do link competence to tasks and procedures. What these studies fail to illuminate is that technical competence is taken for granted (it is not that it is unimportant, it is in fact the foundation of competence) and when technical competence is assumed then the human skills of the nurse become the most important indicator of good nursing.

Fosbinder examines interpersonal competence in a study based in the USA (Fosbinder 1994). Interview and observational data were gathered from forty one patients and twelve nurses and data analysed using the principles of grounded theory (Fosbinder 1994). An emerging theory of interpersonal competence was developed. Fosbinder (1994) identifies four major processes of interpersonal competence as defined by patients:

- Translating: informing, explaining, instructing and teaching
- Getting to know you: personal sharing, humour, being friendly and 'clicking'
- Establishing trust: being in charge, anticipating needs, being prompt, following through, enjoying the job
- Going the extra mile: being a friend and doing the extra.

Although this theory is developed and explained it does not go further to examine how these processes could be assessed and more fundamentally whether patients would wish to assess nursing care as conceptualised in this way. However, all of these processes were identified by patients participating in the study reported in this thesis as important attributes of nurses, these findings will be reported in further chapters.

## Conclusion

Having evaluated the evidence on competence based education in nursing, Watson *et al* (2002a) suggest that the literature 'does not support the use of competency based approaches to nurse training' (Watson *et al* 2002a: 429). Although there is much criticism of competence education and assessment in the literature, few alternatives or suggestions for the ways in which the competence based approach can be supported are offered and the nursing curriculum continues to be based on the competency model (Dolan 2003).

There is a current tension between what is written about competence based education in nursing and what is happening in practice. Many authors are sceptical about the usefulness of competence based approaches because of the lack of clarity of definition and valid and reliable methods to assess competence. However, in practice many nurse education programmes have competence based education at their foundation. This may be because it is a current educational perspective utilised by many practice based disciplines. The use of competence based education in nursing was reinforced in 2002 when the NMC published the requirements for pre-registration nursing programmes with the stated competencies for entry to the professional register (Nursing and Midwifery Council 2002).

Patient involvement in the development, implementation and evaluation of service is increasingly important, and indeed is embedded in policy directives from the government. One way in which this involvement may be operationalised by patients participating in the assessment of the competence of health professionals. Patient views are already collected in the form of patient satisfaction and experience surveys. However, whether patients can contribute to the evaluation of clinical competence is not clear and questions have been asked about patient involvement in assessment:

- Which patients (e.g. community, hospital based) are best able to contribute to assessment of nursing and midwifery students?
- How far are length-of-stay (of patients) and exposure to different students constraining factors and how might they be overcome?
- At what point in their care should patients rate students?
- What weight should be given to assessments by patients within the overall assessment scheme?

(Norman *et al* 2000: 94)

Research needs to be done to develop theory around this subject, rather than going ahead with involving patients without examining how they conceptualise competence or whether in fact they would wish to be involved in assessment.

Despite the criticisms of competence based education it is still firmly embedded in the education and assessment of nurses internationally, and moves are being made already to involve patients in the assessment of clinical competence. Therefore, this research is timely in examining patients' views of nursing competence and their potential to assess the competence of nursing care.

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# CHAPTER 3

## METHODOLOGICAL ISSUES

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### Introduction

This chapter will provide a detailed account of the theoretical position and methods employed in this research. Data generation, management and analysis procedures will be illustrated. When this idea from study was initially developed from the recommendations of the Norman *et al* (2000) study the initial research question related to whether patients could assess the competence of nurses. Starting from this question rather than a theoretical position, the most appropriate approach to answering the question was sought. Research design should not be concerned with the use of a method that is a 'favourite' of the researcher but the use of one that will adequately answer the research question (Robson, 1993).

A number of approaches to answering this research question were identified. Firstly, it could be possible to administer a rating instrument to patients that would objectively measure nurses' competence. However, as no instrument has been developed to examine competence from the perspective of patients, the instrument would have to be one that was developed (although there is no accepted 'gold standard' for competence assessment) as valid and reliable in measuring competence from the professional perspective. It would then be possible to compare assessment of competence with nurses' assessments and give some indication of whether the patient was 'right' in their assessment of competence.

A variation on this approach would be to ask patients to observe a standardised nursing procedure or event, possibly in a simulated environment, and rate the nurse on his or her

competence in undertaking this procedure. An experienced nurse would also rate the competence of the nurse involved and the scores or rating would be compared. This again would be an objective measure of a nurse's competence from the perspective of the patient.

Although these approaches would have said something about patients' assessment of competence (i.e. does a patient rate the competence of nurses 'correctly' in comparison with the professional view) there would be a number of assumptions underlying these approaches that would have limited the usefulness of the data when exploring patients' views of nurses' competence.

Firstly, there is the assumption that patients' views of competence are automatically the same as nurses, i.e. that instruments or measures of competence developed to assess nursing practice from a professional perspective would be relevant to patients. Secondly, there is the assumption that competence can be objectively measured; this is a concept that is the subject of debate in the educational and nursing literature (Redfern *et al* 2002). Furthermore, one would have to consider the implications if patient and nurse assessments did not match. It would not be possible to tell whether this was because patients and nurses rate different items in an instrument differently, nor could one tell whether the instrument was valid and reliable for eliciting patients' views. In addition, the use of an objective measure of competence decontextualises the experience of nursing care for patients. Admission to hospital is often a time of great stress; the hospital is a powerful institution and within it is a complex social world. The image of the nurse in the public eye is still powerful; the ideas of vocation, hard work and low pay are still significant. Polls prior to the 2003 Scottish election put nurses' pay at the top of the agenda of public concern. It is well documented that objective measures of quality of care in hospital, such as patient satisfaction questionnaires, have a globally positive result, as these questionnaires are generic and do not consider the complex relationships patients have with staff (Bond and Thomas 1992) or the way in which experience of health care is translated into expressions of satisfaction by patients (Williams *et al* 1998).



In view of the above limitations, a different approach was needed, that not only contextualised patients' experience in hospital and acknowledged the influence that this may have on patients' views of competence, but also recognised patients as experts in experiencing nursing care and realised that they may view competence in a different way to professionals. Coupled with these limitations a review of the literature focusing on patient evaluation of nursing care highlighted that there was a paucity of evidence in the area of how patients conceptualise the competence of nurses. In light of the challenges identified above and the lack of conceptual clarity of patients views of competence the initial research question was developed into a more fundamental question. The primary research question for this study became: how do patients construct the concept of competence of nurses? This study will look at patients' views of nursing competence in the practice setting rather than in the simulated situation. This research will focus on competence in the 'real world' of the hospital ward.

An approach was sought that would take into consideration both the context and the social processes of becoming a patient in hospital and examine the impact that these factors have on patients' views of nursing care, rather than making the assumption that assessment is objective and context free. It was considered that an interpretative approach to the research question would take account of some of the issues discussed above. There are of course limitations in utilising the interpretative approach to examine this concept, but utilising this perspective does allow the question of how patients understand nursing competence to be uncovered and how this conceptualisation facilitates an exploration of patient assessment of competence.

The tradition of qualitative inquiry in social research is long and distinguished and is a field of inquiry in its own right (Denzin and Lincoln 2000). Having its foundations in sociology and the work of the 'Chicago School' in the 1920s and 1930s, it was linked with anthropology and was soon embraced by other disciplines concerned with the social world such as education and the health professions.

The interpretative approach is multifaceted and the researcher must make decisions about which particular epistemological stance and methodology he or she will utilise

under the broad umbrella of qualitative research. Grounded Theory is the approach that has been identified as the appropriate methodology for this study of patients' views of nurses' competence. Grounded theory, as a style of research, is widely utilised in the social sciences and often when various methods of research are pared back to their fundamental aspects, it becomes apparent that the core features of grounded theory are readily observable, even if the founding authors of the 'methodology' are not acknowledged.

Even though this approach to social research would appear to be well established, its form and content is contested amongst those undertaking grounded theory research. Grounded theory has been adapted and reinterpreted not only by the founding authors, but also by other social scientists, as will be discussed later in this chapter.

A historical view of grounded theory from its origins in symbolic interactionism to current debates about its character will be discussed. This history will try to account for the disputes in the field of grounded theory and to aid clarification of the theoretical position held in this study.

## **Origins and history of grounded theory**

Although the origins of grounded theory are firmly based in the modernist 'moment' of Denzin and Lincoln's history of qualitative research (Denzin and Lincoln 2000), it has been affected by developments in methods of social research. Grounded theory has not been immune to the debates surrounding the status of truth and knowledge and the position of the researched and researcher and it has been interpreted and reinterpreted in light of them. Glaser and Strauss (1967) suggested in their original text that grounded theory was not a static prescriptive strategy but was open to interpretation and development. This development has taken place and has resulted in competing perspectives on the strategy; these competing perspectives will be discussed later in this chapter.

In order for the grounded theory strategies utilised in this study to be explored, an overview of the main features of grounded theory will be highlighted followed by a discussion of how they have been developed for use in this study.

Grounded theory may be defined as:

the discovery of theory from data systematically obtained from social research (Glaser and Strauss 1967: 2).

Grounded theory is established as a major qualitative approach (Morse 2001). Morse (2001) considers grounded theory to be a particular approach to analysing data that originally evolved through a particular theoretical perspective (i.e. symbolic interactionism). The strategies for analysing grounded theory are described in greater detail than any other method.

In 1967 *The Discovery of Grounded Theory* (Glaser and Strauss 1967) was published and was quickly added to reading lists and embraced by social researchers. Much of the success of grounded theory was due to it being able to answer a number of questions about qualitative research that previous texts had failed to answer, namely, how to start the research (identifying area of interest, avoiding theoretical preconceptions and using theoretical sensitivity), how to do it (through analytical procedures and sampling strategies) and how to stop (when theoretical saturation is reached) (Dey 1999).

Grounded theory methodology has had a significant impact on nursing research. Benoliel (1996) charts the history of its influence since the 1960s, founded on the close community of grounded theory researchers at the University of California San Francisco, where Glaser and Strauss were initially based, and later utilised by nurses internationally. However, although there has been a significant increase of nurses utilising the method, the quality of these pieces of work is contested (Benoliel 1996).

What grounded theory is and what it should be is contested within social research, with a rift between the founding authors complicating matters. Within traditional grounded theory there are two dominant and competing schools: those of Glaser and Strauss, the originators of the method first published in 1967 (Glaser and Strauss 1967). The move in social science towards postmodernism and poststructuralism has resulted in grounded

theory being attacked for its objectivist and positivist foundations. Indeed, these foundations have been retained in both Glaser and Strauss's later works, and are disputed as valid underpinnings for social research (Charmaz 2000).

The grounded theory tradition was developed in the Department of Nursing in the University of California in San Francisco in the 1960s and has remained influential in nursing research. Grounded theory was developed at a time in social research when most sociologists followed Durkheim in their view of the approach to research, which centered on the belief that sociology should be treated as a science. Ethnographies were seen as soft science, impressionistic or equated with journalism. Natural science was accepted as the model for sociological research; sociology was positivistic in nature and its purpose was to produce theory using quantitative methods. Grand sociological theories, such as those developed by Parsons, were viewed to have little connection with what could be discovered by empirical research. Grounded theory methodology encourages an interaction between theory and research (Seale 1999).

Although they did defend qualitative research against the dominant view of quantitative methods, Glaser and Strauss accepted that there should be scientific study of the social world (Charmaz 2000). Data collected should produce theory that could be tested, verified, replicated and predictive. Instead of producing, as an end point, 'thick description' as advocated by Geertz (1993), grounded theory research produces thick description leading to theory development. In other words it produces a set of interrelated categories that describe or explain a phenomenon rather than stopping at description alone.

Dey (1999) considers, in his examination of the grounded theory approach, that there are 'probably as many versions of grounded theory as there were grounded theorists' (Dey 1999: 2). Dey (1999) also suggests that if Glaser and Strauss themselves could not agree on a definitive version of the methodology, an outsider could hardly be expected to fare better in suggesting a view. Melia (1996) gives an overview of this disagreement which started with Strauss's partnership with Julia Corbin and their subsequent book published in 1990: (Strauss and Corbin 1990) 'The Basics of Qualitative Research'. Glaser

responded to this book (Glaser 1992) by forcefully suggesting that Strauss and Corbin had not extended understanding of grounded theory but had gone on to develop another method entirely, which he called full conceptual description. Melia (1996) suggests that it is not clear whether these two schools of thought are actually different, or whether they are just expressing a similar idea in different ways. Although it is clear that much of the wide criticism of the Strauss and Corbin (1990) book was due to the seemingly fixed procedures for analysis, the 1998 (Strauss and Corbin 1998a) second edition, whilst not responding directly to Glaser's criticisms, was less prescriptive in nature.

Grounded theory has many forms and the question of who has the 'right grounded theory' may not be the right question to ask. Dey (1999) claims that in some quarters, certain ontological and epistemological principles must be adhered to for research to 'qualify' as a true example of methodology. There is then the danger that the theoretical position of the study becomes more important than the actual implementation of the research. However, it is important to set down these beliefs that guide the research process and analysis so that the reader is in no doubt where the author lies on issues such as the nature of knowledge and truth, as this will affect the end product of the research.

As the following discussion will indicate, there is a wide range of standpoints from which to view grounded theory. The purpose of the next section is to give an overview of the main theoretical standpoints, not in order to overburden the reader, or the writer, with excessive emphasis on this aspect, but to be able to clarify the author's own theoretical position. This will not be presented as a hierarchy, to privilege one theoretical position over another. It seems easy in the current climate to suggest from a postmodern view point that modernist, objectivist and positivistic research is bad research and cannot represent individuals' lives. Some researchers choose to do objectivist grounded theory because producing an objectivist qualitative work is what they want to do. Grounded theory provides a set of strategies for analysis that can be followed from a number of theoretical positions.

## **Constructing and deconstructing grounded theory**

MacDonald and Schreiber (2001) examine the changing landscape of the social sciences since the first writing on grounded theory was published in 1967. They consider whether grounded theory is still firmly rooted in the modernist moment, as described by Denzin and Lincoln (2000), or whether it can now be situated in postmodernism.

Denzin and Lincoln describe three features of modernist social research which are examined below:

- A quest for respectability: this was achieved in formalising methods by the adaptation of positivist canons to a non-positivist paradigm; for example validity and reliability, generalisability and objectivity. This view of judging qualitative research by scientific rigour has been challenged in recent years (Creswell 1998; Bailey 1997).
- A realist ontology: this indicates the view that there is a real world that can be studied and understood. Glaser and Strauss (Glaser and Strauss 1967) reflected this realist ontology in their original work as well as their later works. This contrasts with the relativist and interpretative perspectives of other qualitative methods.
- A focus on the common (human) experience: – researching voices that are not normally heard rather than theorising at an abstract level.

Although there has been a well-documented (Melia 1996) rift between the original founders of grounded theory, Glaser and Strauss, their work is still firmly in the objectivist camp, giving their data objective status. Glaser (1978, 1992) stays firmly in the positivistic camp reflecting the traditional period (Denzin and Lincoln 2000) of qualitative research, objective and unbiased data collection and reporting. Strauss and Corbin (1990, 1998a) confuse matters by swinging between constructivist notions of grounded theory, by giving a voice to those being researched, and objectivist, by putting a highly systematised spin on the methodology and emphasising how this facilitates



unbiased data collection (although in the 1998 book they refute the idea that these guidelines are strict). Charmaz (1990) states that grounded theory 'displays the tension between being simultaneously subjectivist and scientific' (Charmaz 1990: 1164).

There is a general consensus that grounded theory in its original form is modernist in nature (Charmaz 2000, Dey 1999, Morse 2001) and it has been suggested that it has retained that focus (Travers 2001). However there are now challenges to the view that grounded theory remains objectivist and positivistic in nature. These challenges come from constructivist and postmodernist thinkers.

### THE POSTMODERN CRITIQUE

The central thesis of postmodernism is anti-foundationalism: 'the view that there is no firm ground or truth on which to base any system of beliefs, philosophical principles or research methodologies' (MacDonald and Schreiber 2001: 35). Further to this, any ideology that is represented as truth can be challenged, for example, grand narratives or universal explanations. The focus is on the 'little narrative' rather than grand theory. These little narratives construct meaning and account for human difference. Rather than looking for the norm, difference is a concept that is central to postmodernism. It is not just named theories that are criticised by the postmodernist movement but things such as the modernist belief in progress. Authority is rejected in all of its forms and truth is considered to be constructed both individually and collectively. Truth is regarded as multiple and shifting, as a construction of reality. One of the criticisms of postmodern theory is the difficulty of constructing meaning and making judgements about good and bad. Another is that post-modernists leave nothing when they reject theories.

The question is then: can grounded theory be postmodern? Travers (2001) suggests that although some researchers within particular traditions such as ethnography have embraced post-modernism and have found challenging ways of researching from this approach, grounded theorists have ignored it continuing to rely on positivistic origins that he claims have been responsible for grounded theory's success. MacDonald and Schreiber (2001) examine this question in detail and suggest that there are tensions



within grounded theory. They particularly highlight Strauss and Corbin's (1990) book which has elements that are both relativist and positivistic and therefore 'people can find support for it in any ontology they wish' (MacDonald and Schreiber 2001: 44).

## THE CONSTRUCTIVIST PERSPECTIVE

It is possible then that grounded theory situated in postmodernism may be a step too far in terms of the development of theory. A view that seems to sit more easily is that of constructivist grounded theory, advocated by Charmaz (1990, 1995, 2000, 2002):

[b]y adopting a constructivist grounded theory approach, the researcher can move grounded theory methods further into the realm of interpretive social science consistent with a Blumarian (1969) emphasis on meaning, without assuming the existence of a unidimensional external reality (Charmaz 2000: 521).

This theoretical perspective may then be able to answer some of the criticisms of modernist grounded theory. One criticism levied at grounded theory method is that it is unable to portray sufficiently the stories of participants, but has authority regarding which aspects of data are utilized, valuing the writer's voice above that of the participant.

As in other constructivist methodologies, a constructivist grounded theory arises from interaction between the researcher and participants, the researcher's perspective being part of the process. Thus the outcome of research is different to that of objectivist or traditional grounded theories. A constructivist grounded theory is one interpretation among multiple possible interpretations:

each is a rendering, one interpretation among multiple interpretations, of a shared or individual reality (Charmaz 2000: 523).

It is objectivist in indicating how the researcher came to construct reality rather than being objective about the interpretation itself and assuming it is a shared interpretation. Objectivist grounded theory sets out to develop generalisable, testable and verifiable theory: a constructivist approach in comparison is more tentative but still allows other researchers to develop some of the elements in their own research work. Charmaz (2000) argues that a constructivist grounded theory does not seek truth as an objectivist

grounded theory but it still remains realist as it deals with realities. These realities are however not one-dimensional or fixed:

[t]he constructivist approach assumes that what we take as real, as objective knowledge and truth, is based on our perspective...thus the grounded theorist constructs an image of a reality, not the reality - that is, objective, true and external (Charmaz 2000: 523).

Less rigid rules apply to the development of constructivist grounded theory. Charmaz (2000) describes the highly systematized procedure advocated by grounded theory writers such as Strauss and Corbin (1990, 1998a), and indicates that the more systematized analytic procedures become, the closer they come to the rules of natural science and therefore to an objectivist standpoint.

Charmaz (2000) puts forward an argument for constructivist grounded theory focusing on three main issues: firstly, that grounded theory strategies need not be prescriptive or rigid (as indicated by Glaser and Strauss in the 1967 book); secondly, that a focus on meaning enhances interpretive understanding; and lastly, that grounded theory can be adopted without taking on positivist leanings.

## **The nature of this study**

It has been argued that it is possible for grounded theory to be founded upon a number of theoretical positions from positivism, through interpretivism, to a postmodern approach (Locke 2001). Precisely which approach underpins grounded theory often lies with the particular choice of the researcher. The approach that will be adopted in this study is that of a constructivist grounded theory as proposed by Charmaz (2000).

Even though there is debate about which perspective grounded theory comes from, and exactly how it is used, Charmaz (1995, 2002) identifies a number of features that all grounded theories have:

- simultaneous collection and analysis of data
- creation of analytic codes and categories developed from data and not by pre-existing conceptualisations

- discovery of basic social processes in the data
- inductive construction of abstract categories
- theoretical sampling to refine categories
- writing analytical memos as the stage between coding and writing and the integration of categories into a theoretical framework.

These characteristics, how they are applied to constructivist grounded theory and how they will be adopted in this study will be outlined below.

## **Adopting grounded theory as the research approach**

Grounded theory is a distinctive set of techniques which helps the researcher develop theory from data. The approach is founded on epistemological and theoretical perspectives.

### **EPISTEMOLOGY**

Epistemology is a way of looking at the world and trying to make sense of it. It focuses on the nature of knowledge (Crotty 1998). There is a choice of epistemology that can be utilised for grounded theory: objectivism and constructionist. Objectivism has been already mentioned in this chapter. However, it is constructivism that has been identified as the epistemological standpoint of this research.

Constructivism is founded on the assumption that there are multiple social realities (Charmaz 2000) and that knowledge *is created through interaction* and can be summarised thus:

[i]t is the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context (Crotty 1998: 42).

Unlike objectivism, where knowledge is sought from discovery of objective truth by methods that are seen as impartial and certain, the constructivist view proposes that knowledge is created by human beings engaging in their world. But meaning is not discovered (as in objectivism); it is constructed from what is already in the world. Individuals will construct and reconstruct different meanings of events or objects as they interact with the social and physical world. Therefore, meaning is not fixed; it can change.

## THE THEORETICAL PERSPECTIVE

The theoretical perspective is the 'philosophical stance underlying methodology' (Crotty 1998: 66). In this study an interpretive perspective has been used. Interpretivism is linked to the work of Max Weber and in particular the concept of *verstehen* (understanding). This concept of understanding was seen in contrast to the focus on explanation in the natural sciences. Discussion of this divide in the natural and social (human) sciences can be found in Crotty (1998). The specific strand of interpretivism that has been utilised for this study is symbolic interactionism.

## SYMBOLIC INTERACTIONISM

Symbolic interactionism is the theoretical position that is closely associated with grounded theory and is usually cited in reports of studies as the position taken. It has been debated whether symbolic interactionism is the only theoretical position that can be used with grounded theory (Milliken and Schreiber 2001). However this theoretical position was seen as imbedded in grounded theory to such an extent that it is seen as difficult to 'do' grounded theory and utilise some of the technical procedures, without taking this theoretical perspective.

Symbolic interactionism originated in the 1930s from the work of George Herbert Mead, a social psychologist. His work was written about posthumously and developed by

Herbert Blumer, a student of Mead (Crotty 1998). There are three basic assumptions of symbolic interactionism:

- Human beings act towards things on the basis of the meanings that these things have for them
- The meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows
- These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the thing he encounters.

(Blumer 1969: 2)

In other words, human beings base their own actions on the meanings they have constructed from external stimuli. For example, patients base views of nursing on how they have experienced and interpreted the world of the hospital and this view then affects, but is not determined by, the way in which they continue to present themselves and interact with the social world:

[t]he notion of meaning and its influence on social behaviour is a central and critical idea in the symbolic interactionist tradition (Locke 2001: 21).

Meaning in this context is a process and is not fixed, and individuals are active participants in creating meaning. However, shared meanings can make some actions predictable; this gives some stability to social interaction (Milliken and Schreiber 2001). This research will take into account both individual interactions and the impact of the wider social structures and context; one criticism of symbolic interactionism has been that there is too narrow a focus on individual interaction that ignores wider issues.

Traditional grounded theory supports a scientific version of symbolic interactionism at one end of the spectrum, with the Chicago School occupying the middle ground of interpretivism and the poststructuralists at the opposite end. Constructivist grounded theory moves towards this middle ground, focusing on the Blumarian view of symbolic interactionism (Charmaz 2000).

## GROUNDING THEORY

Grounding theory can be defined as a

systematic generating of theory from data, that itself is systematically obtained from social research (Glaser 1978: 2)

Strauss (1987) suggests that grounding theory is a style of research that

includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making of constant comparison and the use of a coding paradigm, to ensure conceptual development and density (Strauss 1987: 5).

What is central in both of these descriptions of grounding theory is the emphasis on well planned steps or methodological guidelines. Students of grounding theory are often mentored into these procedures by a more experienced researcher who has worked with Glaser or Strauss. This is in contrast to the more haphazard way in which other qualitative approaches have been described (Travers 2001) and to some extent this systemisation has been what has drawn fierce criticism both outwith, and within, grounding theory (Melia 1996; Seale 1999). It is through examining these procedures for data collection and analysis that grounding theory can be fully understood as a methodology.

## THEORETICAL SAMPLING

Glaser and Strauss (1967) indicate that theoretical sampling

is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges (Glaser and Strauss 1967: 45).

Theoretical sampling is the process of actively searching for data to provide the best possible information for theorising on a topic. Glaser and Strauss (1967) give some guidance on initial decisions for theoretical sampling. They suggest that sampling should in the beginning be founded only on a generalised perspective rather than based on a preconceived theoretical view. Glaser further suggests that initial coding

allows the analyst to see the direction in which to take his study by theoretical sampling, before he becomes selective and focused on a particular problem (Glaser 1978: 56)

Charmaz (1990) also suggests that theoretical sampling is best used when some key concepts have been discovered. Initial data collection is commenced with a fairly random group of people, but who are nevertheless 'expert informants' (Glaser and Strauss 1967) who have experienced the phenomenon under study, to begin to develop concepts and theoretical sampling is utilised to focus theoretical development. It is this model of theoretical sampling that was utilised in this study, and this is fully explored in the next chapter.

One of the central features of grounded theory is concurrent data collection and analysis, where new data is then used to confirm and refute original categories. This means that subsequent data collection is carried out in light of initial data analysis. Schedules for collection of observational or interview data will be developed though the research process in order for data to be collected that confirms or refutes initial thoughts and hunches. The interview schedule or topic guide is not fixed in grounded theory research; core questions may be asked to all participants but others may be changed to reflect the theoretical focus of the developing study. Melia (1982) describes this process:

The ideas which the students raised in one interview could be tested out in later interviews if the opportunity presented itself or if a point was potentially worth developing...The testing of hypothesis and search for negative cases advocated by Glaser and Strauss was carried out by this more rigorous follow-up in later interviews (Melia 1982: 330)

The link between data collection and the development of theory is a conceptual code.

## THEORETICAL SENSITIVITY

Researchers need to have theoretical sensitivity in order for them to be able to discover substantive grounded theory (Glaser 1978). Researchers will become theoretically sensitive by immersing themselves in the data and trying to understand what the participants see as being significant and important. Theoretical sampling and concurrent data analysis allows the researcher to become theoretically sensitive to the data.



Existing literature and theory, and prior knowledge and experience of the researcher, can also be used to inform the development of categories, but the categories should not be forced to fit the literature, and should not be used to create categories. Strauss and Corbin (1998b) consider the qualities for the researcher to be being able to pick up the 'subtle nuances' of the data, being able to see beyond the obvious in dialogue with the data, and being able to use their 'sociological imagination' (Mills 1959) to develop meaningful understanding about what is happening. This would be congruent with the idea of constructivist grounded theory.

To achieve theoretical sensitivity, the researcher must begin with as few predetermined ideas, particularly hypotheses, as possible so he or she can be as sensitive to the data as possible. This does not mean that the researcher must start with a *tabula rasa*, as is often assumed. Sensitivity to data is developed by being aware of literature and the general topic area (Glaser and Strauss 1967, Glaser 1978), what may be seen as an open mind but not an empty head (Dey 1993). Strauss and Corbin (1998a) argue that it is how prior knowledge is used that makes the difference; we should use knowledge and experience to inform our analysis rather than to direct it.

Memo writing is an integral way of developing theoretical sensitivity examining pre-existing and developing knowledge. By memo writing, defining codes and categories, and following them through their development, a trail of where ideas came from can be identified to ensure that categories are developed from the data.

## ANALYSIS OF DATA

In order for theoretical sampling to be implemented successfully, there needs to be concurrent data collection and analysis. The ongoing analysis informs the direction of the next interview or group of interviews and is explicitly aimed at developing theory. Within the constructivist perspective, meaning, as is implied in some texts, is not discovered but created (Dey 1999, Charmaz 1995). The researcher must engage with the data and use his or her theoretical sensitivity in order to create theory.

Glaser (1978) and Charmaz (1995) identify a two step coding process in data analysis. Coding is a way of actually defining what the data is about; the codes have to be created as the researcher engages with the data.

Coding gets the analyst off the empirical level by fracturing the data, then conceptually grouping it into codes that then become the theory which explains what is happening in the data (Glaser 1978:55).

Glaser (1978) and Charmaz (1995) advocate line by line analysis as the first step in coding. This involves each line of data (or more realistically incident by incident, but being careful to not take the overview approach of reading over the data quickly to give an impressionistic development of categories) being examined and named in as specific terms as possible. It is helpful to keep the codes active by asking ‘what is happening here?’, or ‘under what conditions does this happen?’ Analysing line by line also helps the researcher to stay grounded in the data and not let any preconceived notions define categories, although they may warrant their inclusion if data suggests this. Constructivist grounded theory acknowledges that the researcher’s perspective and interest will influence coding at this stage. A researcher from one disciplinary perspective may be more alert to some aspects of the data than others. This is reflected in the view that researchers from the constructivist perspective see their coding as only one view among many, not an objective truth.

Initial substantive codes can vary widely in topic area and it is conceivable that one line of data may be coded in a number of ways. Coding is a process that is constantly reviewed, using the constant comparative method, and if a new process emerges in a later interview, all other interview data should be re-examined in light of this and pursued in further interviews. Using the constant comparative method, incidents are compared to each other and categories and their theoretical properties are generated (Glaser and Strauss 1967). Initial codes help to break into the data to see social processes and help to identify what kind of data should be collected next (Charmaz 1995).

The second step is theoretical coding (Glaser 1978).

Theoretical coding conceptualises how the substantive codes may relate to each other as hypothesis to be integrated into a theory (Glaser 1978:72)

This involves identifying patterns in the coding and using the codes that appear regularly to examine large amounts of data. These codes are the most important analytically and can explain a lot of the data. During this process there is still a dynamic process between the data and codes; it is not a linear process going from initial coding to theoretical or focused coding:

[f]ocused coding allows you to create and try out categories for capturing your data. A category is part of your developing analytic framework. By categorising, you select certain codes as having overriding significance in explaining events or processes in your data. A category may subsume common themes and patterns in several codes (Charmaz 1995: 40).

Theoretical coding then develops the categories conceptually and in abstraction whilst still being grounded in the data. As a code, or codes, are raised to a conceptual category the researcher begins to define the category's properties such as specifying the conditions under which it exists and showing how this category relates to other categories. Categories may be *in vivo*, that is taken directly from the participants' words, or may be theoretical, developed from the researcher's definition of what is happening in the data, or developed from participants' substantive realities.

All of the development of codes and categories is done utilising the constant comparative method. Incidents, individual codes and categories are all compared in order to fully define and delineate codes and categories, so it is clear why data should be coded as one code or category or another. This constant comparison and definition of codes and categories allows the researcher to see what is on the fringes, what the ambiguities are, so that further refinement of the theory may be made.

#### MEMO WRITING

Memo writing is a significant part of the analytical process in grounded theory (Glaser and Strauss 1967). If the stage of memoing is missed out, then the researcher is not doing grounded theory (Glaser 1978). The codes and categories go some way towards analysis, but until the analysis has been fully written up it is not complete. Dey (1999) suggests that to assume that coding *is* analysis is a mistake that some researchers make.

Charmaz (1995) explains memo writing as the 'intermediate step between coding and the first draft of your completed study' (Charmaz 1995: 42). The memo helps the researcher to explore and define processes and actions that are included under the code or category, how the category has developed and changed and how various categories fit together. Raw data can be brought into the memo to illustrate examples of analysis from the data and allows the researcher to make precise comparisons. Memos should not be treated as complete and fixed, as they are initial analytical thoughts and can be altered as thinking changes. It is possible that the researcher will go back to the field to test out some of the assumptions developed in the memo. When memos have been developed and filled out and categories connected with each other, it is then possible to write the first draft of the theory. Writing will further develop memos and draw the analysis together.

#### THE DEVELOPMENT OF THE CORE CATEGORY

Glaser (1978) highlights the importance of the core category for grounded theory:

[t]he generation of theory occurs around a *core* category. Without a core category an effort of grounded theory will drift in relevancy and workability (Glaser 1978: 93).

The core category accounts for most of the variation of data and therefore most other categories relate to it in some way. The core category is a more highly abstracted category but still must remain grounded in the data. It explains how categories are related, variation in participants' behaviour and the story of the findings. The major categories are related to the core category and these categories show how the core category works in the lives of participants.

Dey (1999) identifies the characteristics of the core category as being central (accounting for most of the data), stable (being recurrent in the data) and sufficiently complex, incisive, powerful and variable (sensitive to variations). The development of the core category helps to conclude the research by setting the boundaries of the theory, as codes and categories that are not directly relevant are discarded (Dey 1999).

There are again some difficulties raised by the concept of the core category. The way in which the founders of grounded theory wrote (Glaser and Strauss 1967) about the development of the core category has led to a discussion in the literature of how the concept can be taken forward. It is not clear exactly how core categories are identified, with the key issues being whether the core category is discovered in the data or if it is researcher choice that leads to the identification of the category. There is also the issue of how a decision is made if more than one category looks as if it has the characteristics of a core category (Dey 1999).

Within a constructivist grounded theory, although the core category *will* be suggested by the data, it is the researcher in dialogue with the data who will identify the core category. This may mean that the core category may be chosen because it reflects the interest of the researcher, which will make it meaningful in the context of the questions that started the research, which are often discipline specific. Constructivist grounded theory would not claim to have the right answer which can be objectively distanced from the researcher and his or her professional and personal standpoints. This may be criticised by those from an objectivist standpoint, but at least the way in which the core category is identified is made explicit. It may be possible for the researcher to offer alternative accounts of the core category and thus the development of theory.

Whether the development of a core category is necessary is also debated. Charmaz (2000) was not able to identify one overarching theme from her research as her grounded theory of experiencing chronic illness consisted of many processes. Glaser (1978) also indicated that it is possible to have more than one core category. Two or three categories may present themselves and to subsume these all into one category and not be able to discuss how they relate to each other would remove their powerful theoretical functions.

What is clear is that the researcher should not rush to decide what the core category, or categories, are and these should not be predetermined by the researcher but be developed from the data into a theory that 'works' and is meaningful and plausible to the reader.

## SATURATION OF CONCEPTS

Dey (1999) suggests that grounded theory as an approach to research not only suggests how to initiate research, how to select, code and analyse data, but how to conclude the research. Theoretical saturation of concepts is the point at which the data collection and analysis cycle can conclude:

“‘[t]heoretical saturation’ refers to concepts, not data, and identifies a point where no further conceptualization of the data is required (Dey 1999: 8).

As Glaser and Strauss (1967: 61) define it, ‘saturation means that no additional data are being found whereby the sociologist can develop the properties of the category’. Dey considers that the term saturation has appealed to many qualitative researchers but has come to mean exhaustion of data sources (which he labels sufficiency rather than saturation) rather than full development of a category. Glaser and Strauss (1967) identify that saturation relates to the conclusion of theoretical generation but not confirmation, as the ideas are incomplete. This would require verification and highlights the tension between generating theoretical insight and accumulating evidence and exemplifies the rift between Glaser and Strauss in later years.

Without this verification, categories should be considered incomplete or suggestive or indicative in their claims (Dey 1999). However, we still seem to be left with the question of how to judge when theoretical saturation has been reached. Dey (1999) suggests that this difficulty is compounded by the unexpected, that new conceptualisation may be waiting just round the corner and that it may be possible that new data or a re-examination of current data may throw up a new conceptual perspective. So how do we know when to stop if we always have the uncertainty that a fresh look at the data may lead to further refinement of categories or development of new ones? Dey argues that this may be possible by closely following established procedures of data collection and coding where the



potential for unpredictability may be reduced and made more manageable partly through the procedures that the analyst adopts in collecting data. As analysis develops, it becomes more focused and the procedures for sampling and data collection become more circumscribed (Dey 1999: 118).

This theoretical narrowing during data collection, using theoretical sampling and sensitivity, with all properties of a category being explored, will limit the unpredictability of new theoretical developments being identified to some extent. This does not however take into account the pressures that a researcher may be under in terms of practicalities, such as time and resources and gaining access to participants. Charmaz (1990) suggests that theoretical saturation will never be reached because the researcher will continue to have questions about the data; these will not always be answered by sticking to the procedures of theoretical sampling. This difficulty in the definition, or indeed in the debate about the existence of theoretical saturation, might find a practical solution in the development of plausible stories (Melia 1997).

## DATA GENERATION

Methods of data collection in grounded theory are not clearly detailed. However, grounded theory research has become synonymous with interview studies (Charmaz 2000). A number of different methods have been utilised for data collection (Locke 2001), for example, Melia (1987) successfully used ethnographic interviewing, with the focus being gathering rich data for thick description (Geertz 1993). A number of studies have produced grounded theory using the interview alone; Charmaz's (1997) study of chronic illness is one example, but data collection in grounded theory is still disputed (Charmaz 2000). Qualitative interviewing has been chosen as the method for this study, although some may see this as a limitation as the interview is only one way of understanding the social world. Further discussion of the use of the interview in this study will be found in the following chapter.

Charmaz (2002) suggests that qualitative interviewing is particularly helpful in grounded theory, although it may be dismissed by some qualitative researchers as there are inherent assumptions about power, where the researcher assumes the most powerful



position. In grounded theory this control of interview is necessary, as the interview is a guided conversation and there does have to be some narrowing of topics and questioning as well as control of the data, to be able to sample and collect data theoretically. However, in constructivist grounded theory the researcher does not claim power because of the position they hold as researcher, but as an individual theoretically sensitive to the data. However, a position of power, even if it has not been claimed, can still exist within the interview dynamic.

There is still some disagreement about what data are best for grounded theory. Sources of data for grounded theory are not well specified by the originators' 'all is data'. Although data in the original incarnation of grounded theory developed by Glaser and Strauss (1967) was based on interview and observational data, Benoliel (1996) suggests that there has been a move away from observation to interviews as the sole method of data collection. There does appear to be discomfort in some quarters regarding the sole use of one-off interviews for qualitative research (Warren 2002). Morse (2001) does suggest however that the use of unstructured retrospective interviews is ideal for gathering data for the development, particularly those that allow the participant to tell their narrative so that social processes can be uncovered. Morse suggests that observational fieldwork in contrast only produces a snapshot of time which does not allow an overview of the process. Travers (2001) also describes the difficulty of gaining access to institutions to conduct fieldwork and suggests an interview based study as a viable alternative. Melia (1987) goes further than this by suggesting that

[t]he close involvement of the researcher in the production of data is as true of the informal interview as it is of participant observation. The field data produced are handled in much the same way that the field notes of participant observation might be. The distinction in the literature, notably by Becker and Geer, between the interview and participant observation, is perhaps more of a conceptual distinction when it comes to considering data collection and analysis (Melia 1997: 191).

The decision not to undertake fieldwork was informed by the writing of Erving Goffman on fieldwork. Goffman (1989) writes that

[t]here is a freshness cycle when moving into the field. The first day you'll see more that you'll ever see again. And you'll see things that you won't see again (Goffman 1989: 130)

Melia (1987) indicates that as a nurse, with insider knowledge, she did not enter the world of student nurses as a 'naive observer'. This familiarity with the world, Melia suggests, would have brought problems to the collection of observational data. Like Melia, the researcher already knew much about the hospital system and was concerned that they would only see this through the eyes of a nurse and would not have the 'freshness cycle' that Goffman considers to be so valuable when entering the field.

## QUALITATIVE INTERVIEWING

Traditionally the interview is based on conversation with the participant, with the researcher asking questions and the participant responding (Warren 2002), although there has been increasing discussion about whether this is the most appropriate dynamic in the interview setting (Warren 2002).

Morse (2002) suggests that there are two assumptions that underlie qualitative interviewing: firstly, that participants are familiar with the world that is being researched and can be considered expert on the subject under study and secondly that good participants are those who can articulate experience and describe the everyday world in which they live:

[t]he researcher's purpose in conducting the qualitative interview is to obtain data that will enable him or her to understand the experience and interpret the everyday world of the respondent and to communicate the respondent experience, in all its rich detail (Morse 2002: 318).

Interviewing may be founded in a number of epistemologies. They may be conducted to elicit factual, objective information; others may be based on a constructivist notion of the creation and interpretation of knowledge through interaction. The purpose of most qualitative interviews is to derive meaning through interpretation (Warren 2002).

Perspectives may change throughout the interview. The participants (both researcher and respondent) talk to each other 'not from stable and coherent standpoints, but from varied

*perspectives'* (Warren 2002: 84). The researcher's position is often seen as being from the discipline that the researcher is representing, but it is now recognised that the researcher may come from perspectives that are not disciplinary but based on personal experience. The perspective of the respondent, such as gender or race, may be significant in developing the meaning of interviews, but respondents also take differing perspectives through the course of the interview.

Qualitative interviewing can be seen as a form of 'guided conversation' (Warren 2002: 85) and is linked with ethnographic research. Ethnographic research is founded in the fieldwork tradition of anthropology. A limitation of traditional fieldwork is that the researcher is limited to what they can observe. By including interviewing, perceptions of a phenomenon, such as being a patient, can be elicited from respondents. There has been a tradition in sociology of combining observation and interviewing, but it may be possible to select interviews as the only method of data collection in order to focus the study in a particular setting when the purpose of the study is determining patterns and themes amongst respondents (Warren 2002).

#### INTERVIEWING THE ILL

It has been suggested that interviewing the ill may pose particular difficulties for the researcher (Morse 2000, 2002):

[a]s sick people, participants are unfamiliar with their everyday worlds, and they are often incapable of describing their condition and perceptions, so that researchers have difficulty in obtaining data to comprehend, interpret and generally conduct their research. ... When researching participants who are sick, these methodological problems result in decisions about the timing of data collection, challenges to validity and reliability, and debates about who should be conducting the research (Morse 2000: 538).

As has been previously discussed, the two assumptions underlying qualitative research are that participants must be familiar with their worlds and that they must be able to reflect on their experience. Morse (2000) considers these two fundamentals as being a challenge for research participants who are ill. Firstly, Morse suggests that, due to the sudden onset and severity of most illness that brings people into hospital, patients are not familiar with their environment or being cared for and do not have the language to be

able to describe their experiences. This may not be surprising as it is well documented that professional carers and researchers also have difficulty in achieving clarity of concepts in health care, such as caring, pain or suffering.

However, it may be the particular circumstances of a patient's admission to which Morse attributes difficulty in describing experience. This relates to what Morse describes as instability of the reality of the ill. Patients may be fatigued, in pain, unconscious, or short of breath and this may result in patients having difficulty in keeping track of events or even time. Patients may have difficulty thinking about the future or reflecting on the past. The constant changing of the condition of the patient could be considered a threat to the validity and reliability of the study. However, Morse refutes this claim and suggests that researching the patient world is not concerned with the external view of patients but how the patients experienced this and argues that using a number of methods such as observation and interviews may minimise the limitations of, for example, the interview which would require the participant to be able to communicate orally.

The variability of a patient's condition does have implications for the timing of data collection. Morse (2000) suggests interviewing the patient after the acute event to discuss their experiences, as memories stimulate reflection and discussion of experience. However, there are implications (for the patient) of discussing difficult and stressful experiences with staff, although Morse suggests that discussion of this type of incident can actually assist the patient in coming to terms with what has happened to them even though the intention of the interview is not therapeutic.

Morse (2002) suggests that for the reasons discussed above, a significant amount of research with the ill is done with patients who have chronic health problems. The slower onset of the illness means that patients have an opportunity to come to terms with their illness and this may result in these patients being highly reflective in their accounts of illness. Patients will develop vocabulary around their illness experience in a way that patients with an acute episode will not. A number of chronic illness models have thus

been developed from research with patients (Strauss *et al* 1984; Charmaz 1997; Thorne 1993; Morse *et al* 2000).

#### THE ROLE OF THE RESEARCHER

There may be implications for the researcher, as insider or outsider to the world of the hospital (Morse 2000). What may be helpful is to suggest that a variety of perspectives will be valuable in researching the world of the patient (Morse 2000). Researchers who are not professionals may have some difficulty in getting 'inside' the world of the hospital, which is a closed setting and much of what happens in the hospital may seem strange or even shocking to the outsider. However, the outsider will be able to cast a 'fresh eye' over the environment and not take for granted commonplace events in the hospital ward. The deep understanding that a health care professional may have of the hospital environment and the confidence they may have in interacting with the ill may present some difficulties. Professional standpoints may get in the way of data generation and analysis, but can also enhance the depth of data collection methods.

There may be a number of operational issues associated with interviewing the patient (Morse 2002). The hospital environment itself may raise specific issues when interviewing patients. Access to patients is closely controlled and once ethical approval is gained and the interviewer has access to the ward, negotiation with the clinical team must take place to allow access to a particular patient. If patients are bed bound and sharing a ward or room with other patients it is very difficult to ask personal or emotive questions, as the patients may not feel they have the freedom to answer openly as the conversation will not remain private. Hospitals are busy and noisy and even with patients in a single room it is possible to have a number of disruptions during the course of an interview.

As with interviewing any other vulnerable group, the interviewer must have the awareness to be able to sense that the patient is becoming distressed by a line of questioning and respond to this in an empathic manner. The patient's medical and nursing care should always have priority over research work and the interviewer should discontinue the interview if the patient's condition deteriorates. It is usually

recommended by ethics committees that there is some support in place for the participant if the interview has been upsetting for the patient. It may be difficult for the researcher, who is also a health professional, to draw the line between a therapeutic interview and a research interview.

This process of data collection is active with the interview becoming more focused as the theory develops. Very specific questions may be asked in order to explore fully aspects of the theory. It is essential during data collection to ensure that the researcher does not accept taken for granted meanings, which may be particularly problematic if the researcher knows the field of enquiry well. A researcher, however familiar with the area, cannot assume that he or she knows that his or her understanding of a concept is the same as the participant's. Paying close attention to language and how it is used will assist the researcher in understanding the meaning as it is expressed by the participant (Charmaz 1995).

## **Issues of quality in grounded theory**

The question of quality in qualitative research is 'a complex and emerging area' (Creswell 1998: 193). Validity and reliability are often identified as indications of quality in research. Bailey (1997) argues that the concepts of validity and reliability are concerned with the quality of data from the positivist paradigm and they cannot be easily transferred to qualitative research. The search for a version of reality, not a 'single truth' is the concern of qualitative research and this should not be judged by validity and reliability. Although this style permeates writings on grounded theory (Creswell, 1998), it would not be appropriate for judging a constructivist grounded theory.

Bailey (1997) argues further that the researcher must make the process of data collection and analysis transparent, allowing readers to judge its authenticity. An important aspect of grounded theory is that a codified procedure is used for analyzing data and this should allow readers to understand how the theory was obtained from the data.

Rather than focusing on a number of tests for the quality of qualitative research, although strategies to develop theory should be transparent, it has been argued that the



outcome of qualitative research should be plausible stories (Strong 1979; Melia 1987). Rather than get into the complexities of the status of interview data, whether the interview actually represents a situation or whether it is a constructed entity, Melia (1987) suggests that the challenge is to convert data into an explanation of the situation that has resonance with relevant groups and can convince others of its plausibility. In order not just to confirm the researcher's prejudices or preconceived ideas, other stakeholders must be convinced.

### CRITICISMS OF GROUNDED THEORY

Alongside the criticisms noted earlier in this chapter from postmodern social researchers, there has been some concern about how grounded theory is carried out. There is criticism that much reported 'grounded theory' is not grounded theory at all due to lack of adherence to key methodological issues (Seale 1999; Wilson and Hutchinson; 1996 Charmaz 1990).

Becker (1993) identifies a number of common pitfalls in grounded theory research. These include failing to undertake theoretical sampling and concurrent data collection and analysis and using computer programmes to identify the core category on frequency of occurrence alone. Wilson and Hutchinson (1996) further this discussion of methodological mistakes to include the muddling of methodology; importing preconceived ideas into the data collection and analysis; the use of grounded theory to 'pad out' survey findings and premature closure of analysis leading to highly descriptive studies with little theoretical weight.

Charmaz (1990) however suggests that what may be happening with grounded theory is something else: 'Weaknesses in *using* the method have become equated with weaknesses inherent in the method' (Charmaz 1990: 1164). The assumption within this statement is that criticisms of how some researchers are conducting grounded theory are devaluing the method itself.



## Summary

Grounded theory is a well established strategy, using concurrent data collection and constant comparative method of analysis, for the development of theory grounded in data. Its unstructured approach allows the exploration of new ideas, with the focus of the theory being determined by participants' experiences rather than a hypothesis or the researchers preconceived ideas. This of course means that the researcher may not be able to predict the analytic relevance of any 'variable' such as age or gender and means that the researcher must be open and adaptable to the direction that the research might take.

Methods of analysis, particularly memoing, provide an 'audit trail' of decision making through the research process. Theoretical ideas can be traced back through writing and memoing and the development of the properties of categories. The procedures to generate data and when the researcher should stop are also transparent. This has lead to the claim that grounded theory is good social science (Glaser 1978).

The techniques of grounded theory are used widely in the social sciences but many researchers still resist acknowledging them as grounded theory in part because of the prescriptiveness of later works from the founding authors, with Glaser's eighteen coding families (Glaser 1978) and Strauss and Corbin's detailed levels of analysis (Strauss and Corbin 1990). Despite these misgivings, it should be remembered that grounded theory has developed from these original conceptions, as Glaser and Strauss expected, and new interpretations of the approach are in use reflecting the development of social science in the twenty first century. The next chapter will examine in detail how grounded theory was employed in this study.

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# CHAPTER 4

## HOW THE STUDY WAS CONDUCTED

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### Introduction

This chapter will examine how this particular grounded theory study was conducted, it is written in the first person as it relates directly to how the study was conducted and reflects on this process. The study commenced in 1999 and data collection was concluded in January 2003. The first year of the study was spent developing the study design and preparing for fieldwork. This preparation was undertaken formally, whilst completing an MSc by Research and in preparation for transfer to PhD registration.

Design issues in qualitative research are complex with difficulties arising in fitting an open-ended study into a predetermined design (Kvale 1996). The nature of research in the interpretative tradition makes it difficult to develop a set of detailed steps and procedures until the research is underway. Sandelowski *et al* (1989) highlights this issue:

the research proposal for a study that involves an emergent research design compels the investigator to negotiate the paradox of planning that should not be planned in advance (Sandelowski 1989 *et al*: 77).

Employing grounded theory as a methodology for the study may further complicate this issue. In order to allow theory to be generated from data rather than imposing an explanatory theory on the data, the researcher is encouraged to refrain from reading extensively in the area or developing firm ideas about the area of research. Reading in the area of interest and examining the approach other researchers have taken to the area of study is a strategy that is often employed at the design stage. So there is a tension between reading work in related areas to situate the study in a context, to examine other

methods used, and developing firm ideas about these issues that will drive the analysis. These issues have been discussed in the previous chapter.

It was not clear then, when I started, exactly what direction the research process would take. In this chapter I will summarise the research process as it developed and will discuss briefly the major analytic themes that drove the theoretical direction of the research.

## **The research process**

### THE RESEARCH SETTING

Research design is about making a number of choices, and a choice had to be made regarding which clinical area would be identified as the research setting. Patient care in the UK occurs in a number of different settings, both in institutions of various kinds and in the community. It was decided that participants would come from a population accessing health care in hospital in the adult physical health setting. From a research design point of view, utilising general hospitals would provide a large population from which to select a sample and potentially a large amount of variation in the population. This variation in population is key to developing substantive theory. The research setting was an acute NHS hospital trust in Central Scotland.

### THE RESEARCHER'S ROLE

As the researcher I was also a nurse on the professional register. If this research was being conducted with an objective perspective, the potential complication of being allied with the profession I was studying would not be an issue, as knowledge from this viewpoint is seen as objective, value free and not affected by any outside issues. However from a constructionist perspective the researcher is acknowledged as having an

influence on both the data collection and analysis (Charmaz 2002), and this will be discussed later in this chapter.

## GAINING ACCESS AND ETHICAL ISSUES

There are obviously ethical issues involved in asking patients to talk about their inpatient nursing care while they are still in hospital. The study underwent approval within the university, in the NHS Trust where the patients were recruited and ethical approval was gained from the Local Research Ethics Committee (LREC).

It was clear from the outset that one of the most difficult aspects of this study would be to gain access to patients in the hospital. There are necessary safeguards to protect patients against any physical or emotional harm that they might suffer resulting from taking part in a research study and to ensure that patients are entering into a study from a position of informed consent. Two processes were key to gaining access to patients. The first process was to gain ethical approval from the LREC and the second to negotiate access to patients at hospital and ward level. These will be discussed in turn. Both processes had to be tackled at the same time as the Hospital Trust required ethics approval before it would allow access, but the ethics committee required trust management approval before it granted ethics approval. It became difficult to ask senior Trust managers to sign an LREC application form when they needed LREC approval to give final approval to the research at Trust level. A great deal of negotiation took place to get agreements in principle for the research to be undertaken in the Trust, but pending ethics approval (copies of letter to lead medical consultant and clinical managers and information sheet can be found in appendix four).

There were a number of levels of the hierarchy that needed to approve the research within the Trust. The hierarchy was restructured twice during the course of the project: titles changed, directorates changed their boundaries and people regularly changed job. As a result, it often took days to find out which individual had responsibility for a clinical area.

#### LOCAL RESEARCH ETHICS COMMITTEE (LREC) APPROVAL

Ethical approval was sought from the appropriate LREC; this was a long process that took six months from original application to full approval. A number of changes were underway in the organisation of ethics committees at a local level that resulted in delayed review of applications. Some changes to the original proposal were requested; of particular note was the request for the researcher to provide evidence of indemnity insurance. The University of Edinburgh agreed to provide this cover. A number of other issues also required clarification for the committee; these related to the research methodology and may indicate the committee's experience in reviewing medical research proposals with an experimental or survey design and being less conversant with qualitative methodology (Tod *et al* 2002). The LREC also requested that the research be approved by the lead medical consultant in each clinical area I intended to recruit patients from. This proved, to be a major factor in the length of time it took to get access to patients, as I will discuss in the next section.

#### LOCAL ACCESS AT HOSPITAL TRUST LEVEL

Gaining access at the Hospital Trust also proved to be a lengthy and difficult process. Once approval was given by the nursing and medical manager of the Hospital Trust, access had to be negotiated at unit or directorate level with directorate managers (usually nurses) and lead medical consultants. Individuals were contacted by letter with a full explanation of the project and proof of LREC approval. A number of managers requested a meeting to discuss the research. These meetings proved difficult at times with concerns relating to the perceived 'threat' of patients evaluating staff. After negotiation and further explanation of the project, it was possible to gain access to the charge nurses to ask for access to patients on the ward.

As the ethics committee had requested that permission from lead consultants also be sought before gaining access to patients, letters of explanation were sent out to consultants. However, many consultants did not respond for some time, up to six months in one case. Some responses were positive giving permission, but many granted permission whilst also raising concern about the study design. This concern generally

related to the perceived lack of generalisability of the study (due to its small sample size) and therefore the usefulness of undertaking the project. A letter was sent to these consultants thanking them for the access to patients and reiterating the purpose and nature of the study. I offered to meet with consultants to further discuss any concerns but this option was not taken up by any individual.

Access at ward level through the charge nurse was easier to negotiate due to my familiarity with the setting and because I was able to reassure the charge nurse that nursing care would be the priority during data collection. I set up a meeting with every charge nurse concerned to discuss the study. Information sheets, consent forms and inclusion/exclusion criteria were discussed with staff at this meeting. These charge nurses became an essential contact within the ward area with most of the discussions about patients participating in the study taking place with these nurses. The charge nurses were able to inform other ward nursing staff about my work and encouraged them to support the project.

## RECRUITING PARTICIPANTS

When patients were identified as being potentially suitable for participating in the study by the nurse in charge, the nurse and myself determined whether the patients should be included or excluded from the study. The recruitment procedures did raise some issues regarding the nurses as gatekeepers to the patients. I had some concern that the nurses would pick the 'best' patients for the study rather than identifying them with the inclusion and exclusion criteria in mind. I tried to minimise this by involving the nurses who had most understanding of the study and checking out with the nurses exactly why a particular person would not be eligible. Foster (1996) examines the importance of gatekeepers in the research process, investigating their motives in allowing research to be undertaken, or utilising it for their own ends, and refusing access.

## INCLUSION/EXCLUSION CRITERIA

All patients were considered to be eligible for the study unless they met the exclusion criteria. Inclusion criteria for the study focused on the participant's ability to give informed consent to participate. For example, patients who were confused, acutely unwell or distressed about a diagnosis were not considered eligible for the study.

The criteria for inclusion to the study were that study participants were inpatients in the designated clinical area at the time of recruitment to the study, and had been an inpatient for at least three days, so they had sufficient experience of nursing care to participate in the interview. Patients recruited from the inpatient clinical areas had not been inpatients for longer than twelve weeks. This ensured that the participant had not totally adjusted to the routine of the hospital and care, making it difficult for them to make judgements on nursing care.

Patients who were not judged to be able to give informed consent by ward nursing and medical staff, who were unable to express their views due to communication difficulties, who were involved in other intensive research studies or were unwilling to participate, were excluded from this research. Patients who were excluded were excluded primarily because they were confused.

## THE INTERVIEWS

The interviews were in-depth and qualitative as described by Charmaz (2002) and Warren (2002). A topic guide was developed for the initial data collection period and was refined and developed throughout simultaneous data collection and analysis, although the way in which individual interviews developed was flexible depending on patient experience discussed during the interview. The structure of the interviews followed the suggestion of Charmaz (2002) who suggests using initial open ended questions such as "Tell me what happened when...?" Intermediate questions are more focused, such as "Tell me about a typical day for you," or "Can you give me a positive example of ...?" Ending questions are again open to allow the respondent to pick up on



anything that has not been covered in the interview or anything they feel has been missed out, for example, “Is there anything that you have thought about during the interview that you would like to tell me about?” This type of format makes it easier for the interviewer to get to the individual experience of the participant.

The introduction to the interview, discussion regarding what would happen and explanation of the recording equipment created a comfortable environment in which the participant could discuss their experiences in an informal manner. It is important to develop a rapport with the participant as this is reflected in the quality of data (Kvale 1996). At the end of the interview all participants were thanked for their time and contribution to the research.

The interview questions were developed in order to elicit information about patients’ experiences of nursing care. Interviews were seen as interaction and following the principles of symbolic interactionism, data was created in the dialogue between the participants and the researcher. The topic guide however was not a strict document to be adhered to and it was used as a guide rather than a fixed interview schedule. The first question in particular, “Tell me about your nursing care whilst you have been in hospital,” (see Appendix 1 for initial interview schedule) was developed in order to allow/encourage the participants to tell their story and discuss broadly issues they found important in their nursing care in hospital. The questions were asked in the present tense and primarily focused on the participant’s current admission to hospital although frequently patients discussed past care in order to illustrate points of discussion. Throughout both phases of the research this question was asked first as it allowed the patient to set the agenda and tone for the interview.

Interviews had a conversational tone and the loose structure allowed patients to introduce a broad set of issues. Analysis using the constant comparative method commenced from the outset and issues that arose from interviews were followed up in subsequent interviews. A number of issues that were not anticipated prior to the interview were identified and the flexible structure of the topic guide allowed these to be included.

The most significant change in the interview schedule occurred at the end of the first eight interviews when the theoretical sampling strategy was developed. This allowed an opportunity to reflect in the interview schedule and develop a new topic guide. The interview guide was developed to reflect the theory that was developing from the data (see appendix one for interview schedule phase two). This interview schedule reflected emerging theory and the theoretical sampling strategy. This included asking more specifically about being cared for as an individual and why patients do not complain when care is not as good as they expected it to be, these questions reflected the initial categories developed from the first eight interviews. Specific questions were also included that reflected patients experience with being a patient that would evolve the theoretical generation such as asking patients on dialysis about whether it is possible to identify differences between the ability of nurses when experiencing a technical procedure regularly.

The most significant change in the interview schedule between the two phases was the rejection of a question after phase one relating patients' views of a professional definition of competence. In the initial interviews patients were asked to comment on the professional definition of competence given by the NMC:

‘...the skills and ability to practise safely and effectively without the need for direct supervision’ (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1999 p35).

This part of the interview was rejected for two reasons, firstly for theoretical reasons. All patients agreed with this professional conceptualisation of competence and none offered an alternative view. Although this was an interesting finding (supported by other categories, for example, *‘the exclusivity of professional judgement’* Chapter Seven) that highlighted that patients viewed professionals to be the experts in determining what competence is and how it should be assessed Asking this particular question did not develop the theory. Secondly, methodologically, asking this question stopped the flow of the interview as it moved patients from talking about their experience to considering an objective statement. Also asking patients to comment on the professional view seemed disempowering, it seemed to undermine asking for patient views by asking them to

consider the professional perspective. For these reasons this part of the topic guide was removed for the second phase.

#### WHERE AND WHEN TO INTERVIEW?

When and where to interview patients is a complex methodological issue. Patients spend short periods in hospital and tend to be more acutely ill during their stay than in the past (Bjork, 1995). Patients then may only experience a few days of nursing care before they are discharged. The issue of at what point patients should be interviewed during their trajectory though the inpatient system is complex. It was a concern that if patients were interviewed during their stay in hospital it would be less realistic to expect a true reflection of their feelings, in case they were worried that staff nursing them found out what they had said. There were, however, issues of concern if patients were to be interviewed after discharge. There were practical problems in terms of geography (patients may not live in the research area, making it difficult for the researcher to get access to them at home) and researcher safety (visiting an unknown individual in their own home always has a risk attached to it). Neither of these, however, were unique to this study.

The central question was whether interviewing in hospital was important in terms of the topic of patients' views of nurses' competence. In the initial stages of research design it was difficult to know whether patients would be prepared to reveal their 'real' views because it might affect their care. Although it was considered preferable to interview in hospital as competence assessment could take place in this situation, it was decided that patients would be given the choice of when they were interviewed, either just before discharge in hospital or as soon as possible after discharge at home. The rationale for interviewing patients just before discharge was to ensure that patients were well enough to participate and because patients near discharge will have experienced nursing care though a number of stages, i.e. from acute or emergency care to discharge. Interviewing patients at home as soon as possible after discharge was viewed as important as recall of events in hospital would be easier than at several weeks after discharge. It was decided

that it was possible to sample only those who lived nearby and established procedures in relation to researcher safety would be followed.

I was aware that at times it would be difficult to conduct interviews in ward areas. Every effort was made to maintain the privacy and confidentiality of the participant, such as using a quiet private area in which interviews could take place. All participants were given an identification number on commencing the research to ensure anonymity.

## SAMPLING STRATEGY

Theoretical sampling as discussed in Chapter 3 is the method of purposeful sampling utilised by grounded theorists. This helps the researcher focus on theoretical development from the data. Questions can be asked of participants that 'check out' emerging theory that comes from previous interviews, but where to start? Charmaz (1990) indicates her strategy:

I conduct theoretical sampling only after I have defined key concepts. Delaying focused theoretical sampling fosters gaining an in-depth understanding of the realities and issues at hand. Hence, theoretical sampling fits into the research and analytic process much later than initial sampling of sites, people or documents (Charmaz 1990: 1161).

This is the way that theoretical sampling has been utilised in this study. In the initial stages of data collection, phase one, patients who were asked to participate came from general medical and surgical wards. What was important was not the patient's diagnosis, age, sex or any other demographic or characteristic but that the participant was a hospital inpatient and could tell me about his or her experience of nursing care. Such participants are what Glaser and Strauss would call 'expert informants' (Glaser and Strauss 1967). Once this first phase of data collection was complete it was possible to move onto theoretical sampling to develop the emerging theoretical ideas.

In addition to interview transcripts, notes were made about theoretical or methodological thoughts or developments during the study. These notes played an important part in the development of the analysis from the first interview onwards. Three types of notes are suggested by (Schatzman and Strauss 1973): observational notes; theoretical notes and

methodological notes. Theoretical notes reflect ideas about the development and links between categories. Methodological notes record the researcher's experience of the field and develop thoughts about the method or practicalities of the research. Observational notes can include data from interviews or observation that is not audio recorded. If participant observation is being utilised as a method of data collection, observational notes will encompass the majority of field notes. In an interview study observational notes might include information about a participant's appearance or about their emotional responses during the interview.

## DATA COLLECTION

Following management approval for the research to commence, access to participants was negotiated with charge nurses on individual wards. All patients were considered to be eligible for the study unless they met the exclusion criteria. On arrival on the ward at the beginning of a data collection period, I asked the nurse in charge to let me know which patients were being discharged in the next few days. I always negotiated that I would have the first day of data collection when the charge nurse was on the ward as they were best informed about the project. When patients who potentially would be discharged were identified, the nurse in charge and I determined whether any patients would be excluded due to the above criteria.

Permission was sought again at this time to approach the identified patients, to ensure that from the nurse's point of view it was acceptable for me to see the patients. I introduced myself to patients and briefly explained that I was a researcher from the University who was looking at patients' views of nurses' clinical competence and that as they were due to be discharged in the near future they were eligible to participate. I explained that I was a nurse and that I was undertaking a postgraduate qualification, a PhD. I discussed the funding of the project and explained that I had not worked as a qualified nurse in the hospital and that my research was independent of the institution. I gave a brief overview of the project and what participation would involve and informed the patient of the confidentiality procedures.

Further detail was then given and the information sheet and consent forms explained. Patients were also informed that they could refuse to participate or withdraw at any time without their care being affected and were again informed of the confidentiality procedures. LREC approval had been given providing that there was a 24-hour 'cool off' period where patients could have the opportunity to think about the research and talk to others before deciding to participate. Seven patients during the course of the study used this time to decide not to participate. If when I returned patients agreed to participate, a time and day for the interview was arranged with them. Often patients were happy to be interviewed there and then. Nursing staff were informed of the interview to ensure that it would not interfere with any planned care. The participant signed the consent form just prior to the interview after having an opportunity to ask questions about the study. Three copies of the consent form were signed: one to be kept by the patient; one to be kept by myself and one to be placed in the medical notes. Examples of the consent form and information sheet for patients can be found in Appendix 2.

## **Defining key concepts – preliminary data collection and analysis**

In the initial period of data collection twelve patients from four medical and surgical wards were approached and invited to participate in the study. Eight patients in total were interviewed as four patients withdrew from the study prior to interview. The first six patients were from medical wards and participants seven and eight were from surgical areas. Interviews lasted from 15 to 45 minutes with the average interview lasting for 40 minutes. The hospital wards involved in this initial data collection period all had an office available in which to interview participants and this ensured that there was quiet and privacy for the interviews. Table 2 provides an overview of characteristics of the first eight participants, gathered by the personal information questionnaire, see Appendix 3.



TABLE 2: PROFILE OF PARTICIPANTS – INTERVIEWS 1- 8

	Age	Sex	Ethnic Origin	Marital Status	Highest Educational Qualification	Employment	Home owner
<b>Patient 1</b>	57	F	white	widow	school leaver	unemployed	no
<b>Patient 2</b>	61	M	white	married	school leaver	early retirement	yes
<b>Patient 3</b>	27	M	white	single	'O' grades	window cleaner	no
<b>Patient 4</b>	58	M	white	single	school leaver	long term sick leave – forestry commission	no
<b>Patient 5</b>	57	F	white	married	school leaver	care assistant – nursing home	yes
<b>Patient 6</b>	63	F	white	married	school leaver	retired	no
<b>Patient 7</b>	82	F	white	widow	secretarial college	retired	yes
<b>Patient 8</b>	80	M	white	married	school leaver	retired	yes

## FEEDBACK FROM PARTICIPANTS

At the end of these first eight interviews I asked participants to comment on the interview process, particularly the fact that they had been interviewed in hospital. I asked participants:

- How did they feel about the interview – was it what they expected?
- Did they understand all of the questions – could they have been asked in a different way?
- Did they feel that the hospital was the best place to conduct this type of interview?
- Would they have answered questions differently outwith the hospital environment, for example at home or in a neutral place after discharge?

The responses to these questions were positive. Patients considered the questions appropriate and not difficult to answer. All patients had requested to be interviewed in the hospital and after the interview all considered this the 'best' place for an interview of this kind. It was easier to think about hospital nursing care in hospital. All patients were



interviewed in a single bedded room or in an office or quiet room on the wards; apart from the occasional interruption by domestic staff conversations were private. Patients indicated that it would be more intrusive to be interviewed at home when they wanted to forget about their hospital experience and return to 'normality'. There was also an issue of convenience for them as they did not want the bother of a researcher visiting them at home. Patients stated that they had been honest in their answers and that they did not feel that they had to answer in a particular way because they were in hospital. These comments from patients aided my own reflections on the interviews and led to the writing of methodological notes and development of the interview topic guide as described earlier in this chapter.

#### DEVELOPMENT OF THEORETICAL SAMPLING STRATEGY - MAKING SENSE OF THE FIRST EIGHT INTERVIEWS

After interview eight it appeared that a substantial amount of data had been generated. The analysis that was being undertaken concurrently with data collection identified a number of categories and data collection was suspended to allow for more in-depth analysis writing and some time to think. It also allowed a review of methodological procedures and consideration of the direction of theoretical sampling. Data was fully analysed and written into draft chapters at this time and a number of themes emerged that drove phase two of the study, particularly the sampling strategy.

From the initial codes, six categories emerged:

- Knowing the score
- Time spent/space occupied
- Understanding nursing
- Being cared for as an individual
- Qualified acceptance of care
- Care versus competence

These initial categories provided a framework to develop both the interview topic guide and the theoretical sampling strategy for the next stage of data collection and analysis.

### THEORETICAL SAMPLING IN ACTION

Preparation for further data collection commenced six months after the initial interviews were completed. As the sampling strategy had developed after analysing data from the first eight interviews, access had to be negotiated with clinical areas not approached for the first group of interviews (ethical approval did cover these areas as approval to interview patients from a wide range of clinical areas had been sought in the first instance). This again led to delays of a number of weeks but all clinical areas approached agreed to grant access.

Although a large amount of rich data about patient experience of nursing care and life in the hospital ward was gained from the first eight interviews, it was clear that these patients were having difficulty in articulating ideas about the competence of nurses. Some patients found it hard to describe the competent nurse:

*yes it is no just one particular thing eh that sticks out as it is their everyday work again they cannie dae enough for you they would do anything aye...what they do and they do it to their best ability I think so I cannie just put my finger on certain things*

*(Patient 4, male, age 58: 41)*

or get beyond simplistic accounts or stereotypical views of nurses.

*they are very good, they are angels*

*(Patient 6, female, aged 63: 23)*

The patients whose descriptions of nursing care were the richest were patients who had had a number of inpatient experiences and knew enough about nursing and hospital care to have the knowledge and language to talk about it. This is an issue discussed in Chapter 3 and raised by Morse (2000). The patients in the first phase of this study displayed the challenges described by Morse (2000). Firstly, due to the sudden onset of their illness, patients do not have the familiarity or the language (either medical or lay)

to be able to discuss their nursing care. Secondly, the distress surrounding the patient's admission and variability of their condition may be such that the patient may not be able to reflect on and describe their experience. As Morse suggests, although researching the acutely ill is important, much research on patient experience is conducted with the chronically ill or patients experienced with their care and treatment.

Theoretical sampling is based on the premise that participants can add to the development of theory (Creswell, 1998). It was hoped that interviews with patients who were suffering from chronic illness or could be considered expert patients would be able to develop the categories above. As Glaser (1978) suggests, it was the categories that emerged that were used in the development of the sampling strategy rather than preconceived ideas of which 'variables' would be theoretically important.

*the analyst should not assume the analytic relevance of any face sheet variable such as age, sex, social class, race, skin color etc., until it emerges as relevant. They are never necessarily a property of the process under study until discovered so. Of course, in most preconceived studies of description and verification, they are categorically assumed to be differentiating and therefore of interest irrespective of the data. We have found them often of minor or no relevance in studies of process – e.g. becoming an alcoholic. Therefore they too must earn their way into the theory. (Glaser 1978: 60)*

Although personal information was gathered none of the 'variables' impacted on the theoretical aspects of the study reinforcing Glaser's (1978) view that they were theoretically of minor or no importance.

The particular conditions that the patients were living with were chosen because they were exemplars of conditions where patients are considered 'experts'. Firstly, diabetes; hospitalisation and complications from diabetes most often occur in older patients, and hospitalisation often occurs due to chronic complications such as poor circulation or maintenance of medication regime. Secondly, cystic fibrosis (CF) patients are admitted to hospital with acute episodes relating to their lung disease, for example a severe chest infection. Patients with CF are considered astute when it comes to evaluating health care and there is an active patients' lobby/rights group. This patient group is young; patients with CF without a lung transplant live until their mid to late 20s with poorer survival rates in females (Rosenfeld *et al* 1997). Evidence suggests that age plays some

part in inpatients' views of health care. Levels of satisfaction begin to increase in individuals in their late 50s and early 60s and older people are less critical and more satisfied with care (Calnan *et al* 2003). It was thus important to include different age ranges in the theoretical sample in order to investigate whether age made a difference to views of care. This did not drive analysis but allowed the potential for age to become an important theoretical element. This did not happen.

Both of these groups of patients generally care for themselves. For example, CF patients administer their medication through a central venous cannula and diabetic patients test blood sugar and administer medication either in tablet or injection form. These are complex technical procedures that would require education and practical teaching for nursing staff to be able to undertake nursing.

Patients on renal dialysis were the third group of patients identified for the second phase of the study. These patients came into hospital three times per week to have dialysis. These patients were established on dialysis and came in from home for treatment rather than being acutely ill and dialysed in hospital. Many of these patients worked during the day and had active lives when they were not in hospital, but for a number of reasons could not dialyse at home themselves. Rather than being expert at giving their own treatment (although some had previously dialysed themselves at home), these patients were familiar with receiving a technical aspect of nursing care, dialysis, frequently. It was hoped that they would be able to discuss aspects of technical care that patients in the first phase of the study seemed to have particular difficulty articulating.

The process of gaining access to patients in these clinical areas was similar to phase one. Appropriate patients were identified after consultation with ward staff and consent procedures were followed in accordance with the recommendations of the LREC committee, which have been discussed above. All patients during this phase were interviewed in hospital due to the responses from participants in phase one and as the result of a review of methodological approach on examination of methodological field notes.

Twenty-one patients were approached to participate in this phase of the study and nineteen patients were eventually interviewed. Analysis of interview data continued concurrently with the examination of theoretical, methodological and observational notes. Table 3 summarises the characteristics of patients nine to twenty seven.

TABLE 3: PROFILE OF PARTICIPANTS – INTERVIEWS 9-27<sup>9</sup>

	Age	Sex	Ethnic Origin	Marital Status	Highest Educational Qualification	Employment	Home owner
<b>Patient 9</b>	58	F	white	widow	school leaver	retired - sick	yes
<b>Patient 10</b>	78	F	white	widow	school leaver	retired	no
<b>Patient 11</b>	35	F	white	single	school leaver	unemployed	no
<b>Patient 12</b>	55	M	white	single	college diploma	self employed	yes
<b>Patient 13</b>	72	M	white	single	'H' grades	retired	no
<b>Patient 14</b>	52	M	white	divorced	degree	call centre	no
<b>Patient 15</b>	62	F	white	married	Secretarial college	retired	yes

<b>Patient 16</b>	26	M	white	single	degree	HR advisor	yes
<b>Patient 17</b>	72	F	white	married	school leaver	retired secretary	yes
<b>Patient 18</b>	51	F	white	married	college diploma	computer project leader	yes
<b>Patient 19</b>	40	M	white	single	HNC	unemployed	no
<b>Patient 20</b>	41	F	white	widow	degree	parking attendant	no
<b>Patient 21</b>	28	F	white	single	school leaver	unemployed - mother	no

<b>Patient 22</b>	20	M	white	single	College diploma	unemployed	no
<b>Patient 23</b>	23	F	white	single	'O' grades	Customer services consultant - insurance	no
<b>Patient 24</b>	23	M	white	single	College HNC	Unemployed clerk assistant	no
<b>Patient 25</b>	21	M	white	single	College SVQ	unemployed	no
<b>Patient 26</b>	20	M	white	single	'O' grades	Clerical work	no
<b>Patient 27</b>	29	F	white	single	SVQ	unemployed	no

Looking at Table 2 and Table 3 it can be seen that the average age of participants (48 years) is lower on average than that of the particular hospital trust<sup>10</sup> (58 years) and the

<sup>9</sup> Patients 9-15 were diabetic, 16-21 were dialysis patients and 22-27 were CF patients.

national average in Scotland<sup>11</sup> (55 years). However, the age range in the participant group was significant (20–78 years) and provided an opportunity to look for categories that were based on age. None were identified.

#### FOCUSING THE INTERVIEW- FURTHER THEORETICAL GENERATION

During this second phase the interview topic guide became more focused and concentrated on theoretical development rather than focusing on general issues. As with the phase one topic guide, the interview opened with a general question about the participant's experience of being in hospital. This was to ensure that I was not cutting off the opportunity for the development of new categories in favour of the categories that had already emerged. I focused the interviews by adding questions that reflected the initial theoretical generation and asked questions like *"many of the other patients I have interviewed have talked a lot about the importance of being cared for as an individual. How do you feel this affects your view of nursing care?"* Interviews in this phase are consequently shorter reflecting their more focused nature.

## Data Generation

#### INTERVIEWING

In some situations interviewing the ill is not the most appropriate method of data collection as patients may find participation difficult due to fatigue, communication difficulties or pain (Morse 2002). I interviewed patients who were close to discharge where there were no communication problems. There are limitations to including this

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<sup>10</sup> Figure for 2003 supplied by the Trust

<sup>11</sup> Figure for 2003 supplied by Information and Statistics Division of NHSScotland (ISD Scotland), Health Statistics Unit, Scottish Executive



group of fairly well individuals and Morse suggests that we should also look at the experience of very sick patients. However, these patients were excluded because of the practical difficulties of interviewing the very ill, as well as ethical concerns and discussion put forward from Morse (see Chapter 3).

The interviews in this study were one-off, not repeated or longitudinal, as the particular interest of this study was to examine patients' views in hospital, as well as the social processes that shaped and affected their views. The use of one-off interviews is criticised by Charmaz (2000) who suggests it leads to 'a partial sanitised view of experience, cleaned up for public discourse' (Charmaz 2000: 525). However, I was interested in how patients would conceptualise care in the 'here and now' based on their inpatient experience rather than examining their reflections on nursing care after discharge. Although it would have been interesting to do this, it was not the primary focus of the study.

As a nurse it was relatively easy to fit into the hospital environment. I knew how the hierarchy of the ward worked, who the nurse in charge was and when it would be best to speak to them. Morse (2002) suggests that for researchers not used to the hospital environment it can be intimidating and stressful to deal with. I was comfortable with both the environment and spending time with sick people. In terms of negotiating access to patients, fitting in and understanding the ward environment was invaluable (Morse 2002).

## AUDIO RECORDING

Every interview was audio recorded using a minidisk recorder. A minidisk was chosen for recording rather than a tape recorder as the equipment is smaller and therefore less obtrusive and easier to transport. The sound quality is superior to tape recording as the recording is digital, which also makes the recordings more secure.

Participants were made aware of the importance of recording the interview. It was explained that their views were important and recording was important in order for me

to ensure accuracy of their views and to be able to participate in the interview rather than concentrating on taking notes. Reassurance was given regarding the confidentiality of the conversation recording and the storage of the data itself. Loftland and Loftland (1971) emphasise the importance of recording interview data:

it is imperative that one tape records or otherwise preserves the interview itself. Because there is no strict order of questioning and because probing is an important part of the process, the interviewer must be very alive to the talk of the interviewee (Loftland and Loftland 1971: 88).

Warren (2002) identifies an issue that the recording of an interview raises: that of discussion being on and off the record. Warren suggests that respondents in his studies have continued to speak after the tape recorder has been switched off and this may happen for two reasons, firstly because the participant may discuss his or her own concerns rather than being constrained by the interviewer's questions and secondly because the participant does not want to talk 'on the record' about a particular issue. There were a number of occasions when I turned off the tape and the participant and I continued to discuss the issues raised in the interview. This may have been because the participant seemed to feel that it was more informal.

Much of the discussion after the recorder was switched off was not new and it involved returning to issues early in the interview and retelling important anecdotes. However occasionally a participant would say something particularly theoretically relevant at the end of an interview and at these times I asked patients if I could write down their comments because they were so interesting. An example of this occurred when interviewing one of the renal dialysis patients. We had been talking about the routinised care and that the focus for the nursing staff seemed to be on institutional concerns and pressures and not on caring for the patients. After the tape recorder was switched off, he compared coming in for dialysis to 'cows at the milking parlour'. This was such a powerful image it was worth noting down.

## TRANSCRIBING

Within writing on grounded theory methodology there is some debate about whether word for word transcribing is essential (Stern and Coven 2001). Glaser (1978) himself suggests that full transcribing is not necessary. This view is dismissed by Morse (2001) who suggests that without full transcription there are limits to

the ability of the researcher to use the participants' quotations and consequently the ability of the researcher to truly ground the study (Morse 2001: 8).

Stern and Coven (2001) suggest that researchers have come to rely on technology and contend that just because everything that a participant has said is recorded and transcribed it does not necessarily make for 'good' grounded theory. They also suggest that the focus on recording and transcribing, which of course has only been readily available for a few decades, is the result of the need to present an audit trail or verification of data and theory. This they suggest should already be a part of reporting on grounded theory, memoing and writing should ensure this audit trail without the need for recording. Stern and Coven (2001) conclude that it is not necessary that data is fully recorded or transcribed, only that we examine social process within the context of social interaction.

The authors cited above come from the perspective of experienced researchers and even Stern and Coven (2001) concede that novice researchers may be better advised to record and transcribe all data. With this debate in mind it was decided that interviews would be fully recorded and transcribed.

Following each interview, notes were written as described above: observational, theoretical and methodological. The interview was listened to and preliminary thoughts about themes were noted. The first eight interviews were transcribed by me as soon as possible after the interview and as much of the transcribing of one interview as possible was completed before the next interview was undertaken. Although this was a very time-consuming endeavour it was valuable for the development of the analysis. It was possible to become familiar with the interview content and memos were written during

transcribing that started the analysis as soon as possible as is advocated in grounded theory.

During the second phase of the study (interviews 9-27) an audio typist who had significant experience in transcribing interviews with patients was employed to transcribe the interviews. This was done as I had begun to suffer from repetitive strain injury from typing for long periods and transcribing aggravated this more than any other typing activity. Although this was not an ideal situation as by this point I had recognised the benefits of transcribing data myself, it was felt after discussion with my supervisors that this would be the most sensible course of action for my health.

Poland (2002) suggests that there is little written about the issue of transcription quality in social research, and indicates that there are a number of challenges to the quality of the transcription. Using an experienced transcriber, using predetermined transcription notation systems and thoroughly checking the transcript with the audio recording are suggested by Poland to maximize transcription quality.

## **Data organisation and management**

During the process of data collection a series of memos, ideas and thoughts were written. The analysis and writing developed from all of these documents. Some of this writing was kept in a notebook but the majority was written and stored within the software package utilised for data analysis.

### **USING SOFTWARE FOR GROUNDED THEORY ANALYSIS**

There is much debate about the use of software packages for the analysis of qualitative data (Dey 1999, Stern and Coven 2001, Seale 2002). Stern and Coven (2001) remain sceptical of the use of qualitative software for analysis and take their lead from Glaser and Strauss, who in turn suggest that analysis is more reliable when the researcher

tackles it without the use of software and that time spent learning that package would be better spent on examining the data.

Seale (2002) remains largely positive about the use of software packages citing improvements on data handling storage and retrieval in comparison to manual methods. Retrieval of data from a dedicated software package was also seen as superior to the facilities available on a standard word processing package. Conceptual mapping is also possible. Although there are programmes that allow the development of conceptual maps, some qualitative analysis programmes have this facility embedded within them, which allows the use of categories, memos and data within the map itself. Seale (2002) argues that one of the positive features of the use of analysis software is that it encourages rigour in the study and this view is supported by Dey (1999). Dey suggests that the software can assist the researcher in reading data as it can arrange data in different ways so the researcher can start by looking at different interviews or at different points in the interview. He also suggests that there may be a reduction of error with software as it is easier to check things out than with manual methods and that software can be helpful for validation and can be used for testing out concepts.

It may be helpful to temper this positive review of analysis software with a view from Stern and Coven (2001) who indicate that

unless the beginning researcher understands that any computer programme simply serves as a tool for the investigator, that it is the mind of the student that creates and refines the conceptual framework, she or he is in danger of discovering a thin analysis that fails to illuminate the problems and the process in the scene (Stern and Coven 2001: 29).

In other words, software is no substitution for the brain of the researcher who has to analyse data, think about coding categories and how these link together and develop a theory from which the reader can understand the social world in which the participants live.

Data for this study were typed into a word processing package and then imported into NVIVO, an analysis package. I felt it useful to use the package purely for the features it had for the storage and retrieval of data, which are significantly more sophisticated than

those of a word processing package. During analysis and writing these features were found to be invaluable in the management of data. The facility to write memos into the package and link these with extracts of data or with particular categories was also helpful when it came to writing. It allowed for continuous thinking, writing and analysing of data and allowed me to keep track of my thoughts and exactly where in the data they originated, thus keeping with the ideals of grounded theory. Using software in this manner is similar to Glaser's (1978) discussion on how he used cards and paper, wrote in margins and literally cut out and sorted data and group codes and developed categories and their links with each other.

## DATA ANALYSIS

In this section there is a description of the data analysis. There is ongoing discussion about the analysis of grounded theory data and it is here that the split between Glaser and Strauss is most apparent (see Chapter 3). Strauss and Corbin have been accused of developing a very prescriptive set of procedures for the analysis of data that is more focused on verification than discovery (Melia 1996). As a result of extensive reading on the analysis of grounded theory I decided to adopt a method of data collection that more closely followed the views of Glaser and Strauss (1967) and Glaser (1978, 1992). Rather than breaking apart the data, conceptualising every part and giving it a name as Strauss and Corbin (1990) would suggest, Glaser proposes that

[w]e look for patterns so that a pattern of many similar incidents can be given a conceptual name as a category, and dissimilar incidents can be given a name as a property of a category, and the compared incidents can be seen as interchangeable indices for the same concept (Glaser 1992: 40).

Coding is seen as the first pivotal step in moving from description to conceptualisation and this requires the researcher to examine the data closely. As has been described above this is done not with an empty head, but with a set of sensitising concepts and therefore codes reflect the researcher's interests (Charmaz 2002). Charmaz (2002) suggests that symbolic interactionism itself provides a number of sensitising concepts such as 'identity' and 'self concept'. Within constructionist grounded theory, the principles of



which are adopted in this study, researchers are encouraged to be reflexive about their assumptions and preconceptions that inform their analysis (Charmaz 2002). For example, as a nurse I did make assumptions about how power would be viewed in the nurse-patient relationship by patients, but this was an assumption that was challenged by the participants' views. So although I had an awareness of how my views and knowledge might impinge on the analysis I tried to ensure that I was open in my examination of the data to other explanations and that I sought and considered competing explanations of the data. Charmaz (2002) suggests that you can examine the usefulness of sensitising concepts when coding by asking three questions:

- What if anything does the concept illuminate about these data?
- How if at all does the concept specifically apply here?
- Where does the concept take the analysis?

My supervisors also had a role in challenging my views if they seemed taken for granted or not fully thought through. To discover theory from data the researcher must become theoretically sensitive.

Theoretical sensitivity develops by becoming immersed in data and having knowledge of literature and, in keeping with the ideas of constructivist grounded theory, having an understanding of one's own professional and personal perspectives. Glaser (1978) warns the researcher to be cautious about using pre-existing theory or knowledge in this way, and to ask if the theory fits the data, not the other way round. As the type of grounded theory adopted in this study was constructionist, this pre-existing knowledge was not 'bracketed' in order to ensure data was objective, but enhanced the data collection and analysis. Although pre-existing professional knowledge undoubtedly influenced to some extent the data collection and initial analysis, the above framework of questions was used in order to ensure that these preconceptions were not given precedence. Literature was not utilised to develop categories in the initial stages when categories were being developed but was used later to help draw links between and within categories as described by Hickey (1997).



This idea of forcing theory through the application of preconceived ideas and views is a concern of Glaser (1992) when critiquing the work of Strauss and Corbin (1990). Strauss and Corbin suggest that questions should be asked of data in order to develop theory but Glaser contends that there are very few questions that are neutral when examining data. However, he suggests a number of questions that may be useful:

[w]hat is this study of?" "What category or what property of this category does this incident indicate." "What is actually happening in the data?" and lastly "What is the basic social psychological process or social structural process that processes the main problem that makes life viable in the action scene? (Glaser 1992: 51).

These questions were used in order to keep codes active (Charmaz 1990), as active codes help to give insight into what people are doing or what is happening in the hospital setting and sustain the idea of experience, for example 'learning the rules' and 'mucking in'. A two step process, as discussed in Chapter 3, of initial or open coding followed by selective or focused coding as described by Charmaz (2002) was adopted and constant comparison was undertaken both within and between codes and at category level to develop theory.

Within this study the initial coding for the first eight interviews identified about 50 codes which after further analysis were subsumed into one, or sometimes more than one, theoretical category. The same process was undertaken with the second phase of data collection. At the initial stages codes often were labelled with direct quotes from the interviews such as 'knowing the score' when a patient talked about learning about life in the ward. These labels became more abstract as the codes were reviewed and developed more theoretically.

The analysis process in qualitative research was new to me and did present me with some difficulties in the initial stages. Coding and analysis is a deceptively simple process: breaking things apart to fit things back together to make a plausible story. However, analysis does not just emerge; emergence must be an iterative process. As with Charmaz (1990), initial theoretical ideas developed early in data collection/analysis but in the preliminary stages I separated transcribing, coding and memoing from actual writing with the view that coding was analysis and writing was writing. It became clear

however when writing up the first eight interviews that writing was in fact more akin to analysis than coding. Coding breaks up text and categorises it, but writing allows this coding to develop theoretically (Mitchell and Charmaz 1996). Writing in these early stages allowed me to see that coding does cut things into neat bundles but this is artificial and there is often more than one way to look at data. Codes and categories are interconnected and one segment of data may be saying a number of things. After the 'coding' of phase one there was a recoding and analysis when writing these codes into themes. The lessons this taught me about this process were applied in the (concurrent) analysis and writing of the phase two data.

The initial coding of the data from all interviews was an important process, although by phase two it stopped being seen as the end point of analysis. Coding and recoding allowed me to see how codes had evolved over time, where the ambiguities were and what was on the edge of the codes. Defining codes and drawing boundaries (although seeming artificial at times) allowed consistency in coding and enabled me to make decisions about where data fitted best in this particular constructionist view of patients' views of nurses' competence. At the same time I was reminded that codes are not static and it is possible to change your mind, break codes apart or merge them together when developing theory. The constant redefinition and changing of boundaries' codes was tracked using software to ensure it was possible to follow an 'audit trail' through the data and the evolving ideas.

## SATURATION OF CONCEPTS

The theoretical sampling strategy was developed to saturate the categories but also to ensure that new concepts would not be missed. In the second phase of interviews, rather than finding many new concepts, data began to lead to the theoretical development of categories. For example, in the first phase, a category emerged, *learning the rules of the ward*, in the second phase this category was further explored as CF patients talked about the normal rules of the ward not applying to them and the flexibility of the nurses

negotiating care with them. Early data was reanalysed in light of this and this led to further exploration of the category.

Saturation was reached when a concept could be explained, often using contrasting experiences of participants and across different situations. For example, the highly task orientated organisation of patient care in the renal dialysis unit contrasted with the environment of the CF patients, but theoretical saturation was reached as both groups of patients were still experiencing the organisational or system effect on patient care. Individual examples of a concept were illustrations of a more abstract concept. After six or seven interviews with each of the theoretical sampling groups, no new concepts were emerging and categories were not developing further. At this point, interviewing ceased. Time between interviews was used for initial analysis, by listening to the recording of the interview and writing theoretical notes. This was invaluable for the development of the interviews and deciding when to stop data collection.

## DEVELOPING THE CORE CATEGORY

As the analysis develops in a grounded theory study, an aim is to discover whether there is a core category to explain the significance of the major categories. Dey (1999) suggests that the core category should have certain features:

- Frequency (although this does not mean that the category most frequently identified is necessarily the core category)
- Headline grabbing
- Related to starting agenda
- Relates and explains other categories

A core category was discovered in this study: 'Between you and me' – perceptions of competence: public and private. The properties of this core category are presented in this thesis to explain how the major categories of *knowing the score/becoming a patient*, *recognising good nursing: actions, roles & values* and *reflecting on professional competence* influence views of competence.

It may be possible for the researcher to offer alternative accounts of the core category and thus the development of theory. As this is a constructivist grounded theory I make no claim that this is the only explanation of the data but, using my theoretical sensitivity through theoretical sampling, this is the most plausible story.

## **Writing grounded theory**

As has been indicated above, the nature and place of writing changed throughout the course of the study. Charmaz (2000) suggests that if the approach to grounded theory is constructivist then writing should also reflect this. Charmaz makes suggestions about how grounded theory should be written in order to do this. The use of analogies and metaphors can make hidden meaning and feelings explicit; straightforward language can make the analysis more readable. Both make the theory more accessible.

There is some debate about the use of verbatim quotes in the writing of grounded theory (Charmaz 1995). Grounded theorists do not tend to provide extensive extracts of data but enough to demonstrate the link between the analysis and the data (Strauss *et al* 1985). However, detailed quotes may keep the human element of the researcher at the front of the reader's mind and make analysis more accessible (Charmaz 1995):

you hone your abstract analysis to define essential properties, assumptions, relationships and processes while providing sufficient actual data to demonstrate how your analysis is grounded in lived experience (Charmaz 1995: 47).

Quotes in the following three chapters have been used to illustrate the theoretical points and highlight the fact that these are grounded in the data.

At this point the researcher may turn to the literature to examine any pre-existing knowledge, compare where the work fits and develop this within the writing. Through writing and rewriting the theory can become further defined. Theoretical sensitivity with use of other published work in the area, from a number of disciplines, helped to develop links between categories and confirm or refute existing theory. This literature will be explored in the following chapters as the major categories are presented. Although these

major categories are written as artificially discrete they are all interrelated and a discussion of this will be presented with the data.

## Summary

The flexible nature of grounded theory allowed me to examine patients' views of their care from their perspective. With the open ended questions participants set the agenda for what was important theoretically and the direction of the data collection. Collecting the data in two phases allowed time to reflect on the approach to the study and develop the theoretical sampling strategy. It was also invaluable for allowing me to consider how I was using the method and particularly to examine my difficulty with the separation of the analysis into coding and writing.

The analysis of data moved forward by searching for the major categories and writing the theoretical codes as major categories brings the data together in a complex and well grounded theory. In the chapters that follow an attempt has been made to make sense of how patients construct the competence of nurses and their views on assessing competence. Three major categories have developed from the data: *knowing the score/becoming a patient*, *recognising good nursing: actions, roles & values*, and *reflecting on professional competence: does the nurse know best?* And one core category: *'Between you and me' – perceptions of competence: public and private*.

These are discussed in the following four chapters. How competence is defined by patients and the reasons why (in most circumstances) patients take technical competence for granted, and thus are reluctant be involved with the assessment of nurses, is explored. When competence is taken for granted other aspects of nursing care such as being cared for as an individual and 'going the extra mile' become the important indicators of the quality of nursing care.

The purpose of this thesis is to make connections between ideas to generate 'new' theory, but new does not mean that all categories 'discovered' will not be recognisable to the reader.

‘Every now and then a critic of sociology (including many sociologists) says “Everything of importance has been said by somebody who did not discover it.” Perhaps so, but theoretical coding, in establishing new connections that make ideas (however recognizable) relevant, is what is so often the “new” and “original” about theory. Theoretical codes give integrative scope, broad pictures and new perspective. This is why grounded theory is so often “new” because of its *grounded integration*.’ (Glaser 1978: 72)

Some of the concepts identified in this thesis are not essentially ‘new’ and there is a vast literature on caring, individualised nursing care and other concepts highlighted in the following chapters. The contribution of this thesis is to make new connections and develop theory with categories that have developed from data relating to patients’ views of competence.

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# CHAPTER 5

## KNOWING THE SCORE/BECOMING A PATIENT

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### Introduction

This chapter will present the findings of the first major category, *knowing the score/becoming a patient*. In order to 'bring alive' patients' experiences of being in hospital, direct quotations from patients will be used in this and the following two chapters. As interviews were undertaken in Central Scotland most participants talked in a broad Scots dialect, a glossary of words commonly used by participants is provided in appendix five. Each quotation will be coded with the patient's unique research number, gender, age and the paragraph number from the interview transcript. Where the extract involves discussion between the researcher and the interviewee the words spoken by each will be preceded by the capital letters P for patient and LC for interviewer. The chapter will explore categories and the links between them; some issues will be addressed in more than one section and indeed will be raised again in later chapters. Some extracts of data have been used more than one as is accepted practice with the grounded theory method, highlighting the integrated nature of the categories developed. It is also worth noting that there is different emphasis on the participants in the reporting on categories depending on whether they were primarily developed in phase one or phase two. This means that categories such as 'knowing the score – becoming a patient' extracts primarily come from phase one participants as it was developed in phase one and extracts were more vivid and illustrative as they initially alerted the researcher to the category. Likewise for categories initially developed in phase two such as 'willing dependency' are illustrated primarily with participants' views from phase two. This does



not mean that the category only applies to phase one or two participants, but highlights the constant comparative method in grounded theory when data is constantly analysed and reanalysed in light of the development of categories at all stages of the project.

## **Becoming a patient**

One of the most interesting features of the conversations with patients was that when asked about nursing care, with the first question – *“Tell me about your nursing care whilst you have been in hospital”* – patients discussed their experience of being a patient rather than their nursing care. Patients talked about what brought them into hospital and what it was like to be a patient, with issues regarding nursing care seeming of secondary importance, although they were discussed. It was clear from early on that ‘being a patient’ had an important theoretical place in the study. This chapter examines, from the patients’ perspective, what it is like to be a patient in hospital, with particular emphasis on the socialisation process of becoming a patient.

## **Entering the ward environment**

Patients come into hospital because they need care and treatment that cannot be given or accessed at home or in an outpatient setting. Coming into hospital may be significant for a number of reasons: it may represent a crisis in need because of an acute illness or injury; it may be to determine the cause of particular symptoms; it may signify a deterioration or acute episode in a pre-existing condition or may be to stabilise a symptom resulting from an illness. Patients may feel that at the time of admission they have little control over the situation and rely on others to make decisions for them as to the best course of action. Patients in this study described the experience of coming into hospitals in three different ways:

- as a crisis event
- as a break from the responsibility of illness
- as a disruption or interruption to everyday life

## A CRISIS EVENT

When patients described admission as a crisis event the experience was highly emotional. There was a high level of anxiety and uncertainty and they experienced mixed emotions, including reluctance to come in but also relief at getting care. The patient may have made a choice about whether to present at hospital even if they had been referred by a doctor. The extract below shows that a referral to hospital was ignored until the patient himself realised that he could not cope with his symptoms any more:

*when I first came in I wasn't wanting to come in when I went to my doctors about the pain eh like he thought well he said that ken you need to go to the hospital eh doesn't really know eh and when I got home I just got it drummed into my head it was just a strained muscle so I put deep heat on it em and walked about ...I was walking along there and I collapsed on the road eh and it was a woman who phoned my dad and that to tell him to come round and then it was my dad that bought me up to the hospital but I did have a letter from the doctor saying to come up to the hospital anyway, ah it will just be a trapped nerve it will go away but it got worse and worse I couldn't breathe or nothing that is when my mum and dad says right we need to go up, and that is when I came up here and like collapsed lung...*

*(Patient 3, male, aged 27: 110)*

Even with a more chronic onset of symptoms it may be difficult to acknowledge the need for hospital care. This man had prided himself on not needing hospital care until it came to a point of crisis and he acknowledged that he needed help:

*I always prided myself that I never needed a doctor and I had nothing wrong with me till this legs eh started and it has just gone down hill after that and they tell me, my wife and other people say we saw the difference when I was going down and down and down and you know I was coming to the hospital one visit ... I was just crossing the road and I had to stop and I got up to the bottom of the hill and my sister had got a wheel chair we can't have you walking up there and they took me up to the top and across the road and again I couldn't get rid of this pain I thought well I will have to do something about it and this is the result [amputation of both legs] which was a shock.*

*(Patient 8, male, age 80: 150)*

These two extracts highlight the 'lay referral system' as identified by Calnan (1987). Patients may go through a complex process before consulting with health professionals. Patients may assess their own health needs and ask the opinion of significant others prior to seeking help from professionals. In fact the first extract highlights the case of a patient who actively ignored the advice of his GP to attend at hospital. Patients are not necessarily passive and may actively evaluate their need to seek treatment.

There is some choice for patients in deciding when to seek hospital care and this may be a difficult decision to make. The decision when to seek care is made at the point where symptoms or pain are difficult to cope with without help. When the decision is made to come to hospital, or a referral has been made by a GP, patients can express relief:

*... well before I said I will never go into hospital but when I had to I was damn glad of it*

*(Patient 4, male, age 58: 103)*

Along with relief at being admitted to hospital this patient also expressed anxiety about being a patient:

*aye the first time you have been in hospital everything is strange you are trying to pick up wee bits an pieces and all that and you just do what you are told you know and but the second time you are completely relaxed an you know the nurses from the first time well I have been in this ward 3 times and you know all their first names and you know it's just a sort of family thing you know and you are no scared to come in again you are relieved to come into get help you know and there are all standing waiting to help you right at your beck and call and they canny do enough for you yeah*

*(Patient 4, male, age 58: 202)*

This anxiety at first admission was reiterated by another patient:

*... when a patient is in hospital they feel very vulnerable especially I mean no so much me I know the score, anybody first time in hospital they must be terrified you know all sorts of machinery and needles going about and that you know. So I have noticed that they [the nurses] are very very understanding*

*(Patient 2, male, age 61: 15)*

Patients talked a lot of their emotions and feelings about being in hospital. Vulnerability and anxiety were commonly expressed, particularly when patients were unfamiliar with the hospital environment. Patients cited nurses as being there for them and reassuring patients when they were anxious or frightened:

*especially maybe for, if they've not been in you know, before or you know, or they're going for such and such a test you know, pretty anxious you know. And the nurses always are very good at reassuring you know, like if you're going for certain things you know, scans and things like that you know.*

*(Patient 9, female, age 58: 168)*

Menzies (1960) sees this 'taking on' of the emotional burden of the hospital admission as a central function of hospital care:

The hospital is expected to do more than accept the ill patient, care for his physical needs, and help realistically with his psychological stress. The hospital is implicitly expected to accept and, by doing so, free patients and relatives from certain aspects of the emotional problems aroused by the patient and his illness.

*(Menzies 1960: 8)*

This initial anxiety and unfamiliarity with the ward environment highlighted important theoretical elements for this study. Firstly, that patients have to learn about the ward environment and the role of both patients and nurses: 'knowing the score'. The fact that many of the patients in the initial interviews were not very familiar with the hospital environment may explain why they had difficulty in articulating their experience of nursing care. Secondly, it is also significant that nurses were identified as important in understanding the individual's anxieties and needs. The ward was described as a 'family thing', suggesting comfort and security and responsiveness to patients' needs.

The emotion of coming in to the unfamiliar environment of the hospital can be compounded with anxiety about the cause of symptoms and uncertainty about the implications of symptoms. This young woman who was diabetic described her experience of coming in to hospital with a question over her diagnosis of a secondary condition:

*Because um, well my GP um, when I found it hard to breathe, the first time I came in, he thought it was anxiety because I had a history of anxiety. He says, because the only reason you could have spells and not feeling you could breathe is heart failure. And you know, it's not that. Cause they had listened to my chest and couldn't hear any fluid. It wasn't until I got an x-ray that they seen the fluid.... At night at the weekend when I phoned the doctor...But when the doctor came in then, he found an irregular heart beat, so I was brought into immediate care and they took an x-ray and found fluid and they thought I had nephrotic syndrome.*

*(Patient 11, female, age 35: 76)*

This anxiety was reiterated by a patient who describes her shock at how quickly she became seriously ill and her kidneys failed. She talks about only having two days' notice in which to prepare herself for the diagnosis and its implications:

*...it was all such a shock. Cause I only had 2 days notice. Well by the time I got in. I got blood taken on the Thursday and my kidneys had failed by the Friday...*

*(Patient 21, female, age 28: 60)*

Patients who have a chronic illness may have repeated admission to the hospital due to a crisis event and although, as seen above, some patients find the familiarity of the ward comforting and have built up a supportive relationship with the nurses, the very fact that another admission is needed is upsetting to the patient. Patients made it clear that it is not because of the care that they do not want to be admitted but because of what a hospital admission means to them:

*Nobody likes to come into hospital. That's you know, and when they said I was to come in this time I was really you know, quite upset. Just the fact I think. It wasn't you know, it wasn't aw ... nurses you know. It wasn't that you know. It's just the fact that you've got to come into hospital you know, the word hospital you know. It's not as I say, it's not the care, it's not the nurses or doctors or anything. They're all very you know, very good. It's just the fact that you've got, you know that I had to come in again you know.*

*(Patient 9, female, age 58: 102)*

Coming into hospital as a crisis event leaves patients feeling vulnerable and uncertain about their condition and reliant on health care staff for support and care. Tests and diagnostic procedures are frightening and at times painful and nurses are highlighted as

being reassuring and kind and caring at these times. Even patients familiar to the ward environment may have mixed feelings about admission and this can result in heightened emotion about their condition and may lead to dependency on nurses. This will be discussed further in Chapter Six.

#### A BREAK FROM THE RESPONSIBILITY OF ILLNESS

Other patients saw the opportunity to be in hospital as a chance to have a break from their illness:

*Well I mean I come in here and I won't say I look on it as a holiday, but with a little bit of effort on both sides, I will you know, start injecting again as soon as I go home.*

*(Patient 14, male, age 52: 7)*

This patient suggested that although he does not exactly look at being in hospital as a holiday, he does use it as a break from self administering his insulin.

The patients interviewed with cystic fibrosis (CF) were almost universally positive about coming into hospital. They saw the hospital as a safety net, a supportive environment in which to take a breather from the responsibility of their illness. The interviewees with CF knew the nurses on the ward well; basic functions of the ward such as getting food without effort and nurses taking over technical aspects of care were discussed as positive aspects of a hospital admission:

*Because. It's good because I mean at home it's very impersonal and you come in here it's. You know your food gets brought to ... bed and your IVs come in, your tablets, everything.*

*(Patient 22, male, age 20: 20)*

Another positive aspect of a hospital admission for CF patients would be meeting up with friends; social interaction between patients on the ward was documented in field notes and was highlighted in discussion during interviews. Of great importance to the patients who used the hospital admission for a break in caring for themselves was the familiarity they had with the ward and the staff:



*Em, not really. I think it's just ... being there. So you know when you're at home and you're not feeling well you've got somewhere to go and you ken you're gonna get care from the nurses, and most of them are going to be quite good for you and dae things that you want them to and stuff like that.*

*(Patient 24, male, age 23: 191)*

*Because I'm in regularly, and I mean if I was to come in and every time the staff were different, I mean I wouldn't look forward to come. Well, not that I look forward to coming into hospital, but you know, I wouldn't feel as easy about coming into hospital. And because I know, it's like you build up a kind of, a kind of friendship really if you see what you mean. I mean you get talking to them.*

*(Patient 26, male, age 20: 58)*

For some patients coming in to hospital has been such a significant part of their lives that they considered the hospital a 'second home'. The thought of not having the hospital as part of their life, for example in the eventuality of a lung transplant, in the case of this patient with CF, was difficult to contemplate:

*Well it doesnae bother me coming it. It bothers a lot of other people coming into hospital and it doesnae bother me cause this is like eh, say a safety net ken what I mean. Because I've been coming in since I was 7 weeks old. I mean I wouldnae know anything else. I mean after transplant I'm probably going to be lost for a while, know what I mean? No coming in every 3 months or every 4 weeks or anything like that ken. Having nothing to do with the ward ken what I mean? Just coming in for the odd test so. I prefer it in here than what I do dae on the outside.*

*(Patient 25, male, age 21: 6)*

This young man used his admissions to hospital not only to have physical care for his CF but as a means of forgetting some of the difficulties in his personal life. The hospital ward had become his support network.

For patients where there is a perceived long term burden on them living with a chronic illness the hospital admission may be viewed positively as a break from the 'work' of a chronic illness. This might be called, in professional terms, respite.



## DISRUPTION OR INTERRUPTION TO EVERYDAY LIFE

The third way in which admission to hospital was conceptualised was as an interruption or disruption to everyday life. This was apparent in patients where disease was in the background. They were able to live their lives, work or care for their families in a seemingly conventional way but at times the disease or condition had to be dealt with. In particular, for the patients on renal dialysis, coming in to hospital was seen as an interruption to everyday life:

*But it's a hard situation because I don't feel ill any more. I'm just coming in cause I need this done to help me live you know*

*(Patient 21, female, age 28: 68)*

*I do treat it like that. I think that eh, this is not the centre of my universe and I never want it to be, so yeah I just sort of. Yes so you come in, do your hours then go way and that's the way I like it you know what I mean.*

*(Patient 16, male, age 26: 64)*

One young woman with cystic fibrosis also saw her hospital admission in this pragmatic way:

*Yeah, yeah I think so yeah. Em, because I'm in not that often and it's just .... I just want to get home again. Obviously because I've got [name of her child] and stuff like that, I just want to kind of concentrate on getting better. Yeah, yeah I think a lot of them are like friends and things, so they kind of maybe sit in each other's rooms or whatever it is they do. So it's maybe .....not as desperate to get home as what I might be.*

*(Patient 23, female, age 23: 186)*

These patients had a different attitude towards admission to hospital, which was related to them seeing themselves as essentially a well person. The patients interviewed in this group were all of working age and all had a job or family responsibilities:

*I don't feel we're patients. We're not in a ward situation. We're coming in for a treatment to keep us going.*

*(Patient 21, female, age 28: 6)*

Hospital visits were seen as essential and life saving but lack of choice and having to fit in visits or admissions in the evening or around other commitments put a different slant on coming into hospital:

*Yeah. I have to do it. If I don't do it I die, basically. Got no choice. Just come in, get the dialysis done and get out, as quick as possible.*

*(Patient 20, female, age 41: 132)*

The patients in the renal unit described coming in for dialysis as being like work and frequently described being 'on shift' when coming into hospital and discussed which 'shifts' were the best. The discussion of shifts suggests that patients saw their dialysis as work and comparable to the nurses being on shift, but unlike the nurses they have to work in their jobs or at home and then come on shift, even if they don't want to, as they are having a life saving treatment. This need to come in to hospital on a regular basis for a life saving treatment whilst in everyday life appearing to function as a healthy individual has implications for relationships with nursing staff. Patients attending for dialysis on top of their commitments in their daily lives wanted nurses to engage with them and treat them as equals:

*I mean me being a parking attendant and being in my health and I work 10 hours a day you know, and then I have to come in here you know. Sometimes you get so depressed about it you know. You get more depressed when you see their [the nurses'] faces you know. And if you saw a smiling face it might change your opinion a bit about them.*

*(Patient 20, female, age 41: 82)*

*Yeah I mean a lot of us can work and you know, lead normal lives apart from coming in for dialysis 3 times a week. But they [the nurses] can be quite distant. And I also think they don't spend enough time.*

*(Patient 21, female, age 28: 10)*

These patients did not see themselves as patients in comparison to other hospital patients. They are not ill but need to come in for a specific treatment. As they were more physically able both in their eyes and the eyes of the nurses in comparison to other hospital patients, renal patients had a high level of participation in their nursing care. They assisted nurses in setting up for dialysis by collecting sterile packs and a few were able to site their own needles for dialysis. This led patients to talk about 'grey areas' in care where it was not clear where the responsibility for a task lay.

Patients on renal dialysis found that social interaction with nursing staff was missing, even though they had significant contact with the dialysis unit, in some cases over a

period of years. Patients speculated that they were seen as well people and not requiring psychological care or physical care beyond their dialysis (although renal patients did identify with being well rather than ill, this did not mean that they did not want psychological support to cope with their illness). Another reason that patients suggested interaction was missing with nurses was because the work in the dialysis unit was controlled by strict routine and nurses used this to reduce interaction with patients. This has been described by Menzies (1960) as a defence against anxiety and by Walsh and Ford (1989) as a means of prioritising the priorities of the institution.

Being in hospital provides more than physical care to patients; it can also provide emotional and social care. Patients can use admission to get a break from the responsibility of their illness or see it as a disruption or interruption to their everyday lives. How patients see their hospital admission may reflect how they see their illness, so patients may have expectations about the admission before they arrive.

## **Immersion in hospital life – learning the rules**

In this section learning the rules of hospital life are explored. Analysis of data revealed this to be an important theoretical category. Within the hospital setting rules are identifiable and the patient role has been formulated into an ideal type:

Ideally from the nurse's perspective, all patients should be sick when they enter the hospital, should follow eagerly and exactly the therapeutic programme set up by the staff, should be pleasant, uncomplaining, fit into the hospital routine, and should leave the hospital 'cured'. Good patients handle their illnesses well, are co-operative, as cheerful as possible, comply with treatment, provide the staff with all the relevant information, follow the rules, and do not attempt to disrupt the ward or demand any special privileges and excessive attention.

(Rosenthal *et al* 1980: 27)

The hospital ward functions as a social system and within this, patients have to determine their role and the roles of others in order to understand how the system works. The hospital as a social institution requires roles for its smooth running as this maintains the system. A role can be defined as:

...a combination of normative expectations relating to the rights and duties of an individual in a given social position

(Porter 1998: 23)

A role gives individuals certain expectations about the way that they should interact with one another; if roles are accepted by large numbers of people they become institutionalised (Porter 1998).

Patients in this study talked about their role as a patient and how they fitted into the ward environment. In keeping with the constructionist perspective of this study the view taken here is that patients construct their world through human interaction and pre-existing meanings, although the social and physical world is experienced by most individuals as objective and real (Berger and Luckmann 1967). Although meaning is continually constructed and is subject to change it can be reproduced by social interaction and socialisation (Lupton 2003). Social interaction and socialisation played a significant role in the development of patient understanding of their role and rules were identified by which patients were expected to behave.

## **Knowing the score**

Patients learn about the rules of the ward by experience of hospital admission - the greater the experience of hospital care, the more that patients claimed to know about the hospital environment and the way to behave. This resulted in patients seeing a hierarchy of patients, with more experienced patients being role models in the socialisation of other patients. Experience is a prerequisite to knowing the score.

### **THE ROLE OF EXPERIENCE**

Understanding your role as a patient is complex and patients have to learn about their role and the unfamiliar environment they are in. One patient commented on her unfamiliarity with the ward:

*I felt like the new girl at, day at school or something. It was a bit weird.*

*(Patient 21, female, age 28: 126)*

Previous hospital admissions allow patients to understand how the ward works and how patients should behave. This leads more experienced patients to disapprove of other less experienced patients' behaviour. This suggests that there is an understood, appropriate way for patients to behave. The following extract illustrates this:

*...you would need to be in a couple of times ken, cos I ken people who have been in for the first time in 20 years or something and they are moaning and groaning about this that and the next thing*

*(Patient 1, female, age 57: 324)*

This extract suggests that patients new to the system simply do not understand the social system or the environment. It appears that the more socialised into the role the patient becomes, the more accepting they are of practices that at first seem unacceptable to them; there is no suggestion that criticisms (for example, that nurses seem busy or that patients are not getting individual attention) from new patients are actually an acceptable analysis of nursing work. Patients are socialised into the role of recipients of care that is dominated by the institutional view (there are instances in which patients are critical of care where institutional views take precedence over individual patient need and these will be discussed in Chapter Six). Patients themselves seemed quite proud of their association with this view: the idea that they '*know the score*' (Patient 2, male, age 61: 17) and that they are insiders in this world:

*...but it is nice that you know that you expect these things, I am used to pain this is it mmm If I get a pain it is just there and it will go away and a lot of people are not maybe as tolerant as me about pain ....you know other people if they are new to pain they must just be oh god she stuck this needle in me that size, that is the kind of stories you get*

*(Patient 2, male, age 61: 77)*

This indicates that this patient 'knows the score' about the ward but also that he knows how to behave appropriately. He accepts the pain of his treatment knowing that it will go away and he does not exaggerate or tell stories about the experience. This hierarchy of

patients with insider knowledge, who know the score, set limits on other patients and their behaviour.

## BEING TOO DEMANDING: PATIENTS' RULES

*We're all ill you know...*

*(Patient 9, female, age 58: 145)*

The most significant way in which more experienced patients judged the behaviour of other patients is by whether they were overly demanding of the nurses' time. Patients discussed what they saw as equality of care. They talked about themselves as not wanting special attention, but saw other patients as 'seeking personal attention' (Patient 8, male, age 80: 81) from the nurses. This means that patients have to learn to understand that there are other patients in the ward and that they cannot be too demanding of the nurses. The following extracts indicate that patients are often at pains to show that they are not being too demanding with care and getting attention from nurses, but are aware that other patients can be demanding:

*I dinnae think a lot of people realise that that that the nurses dae so much. And then if they are no one to one with them they are not happy with that either... or if you ask for a nurse they say I will be there the now and they are complaining they have no come. Cos often I fall out with them in the main ward and say its no just your bloody nurse she is everybody's you have got to wait cos you get some of them that just the whole day nurse nurse nurse nipping your heid*

*(Patient 1, female, age 57: 402)*

This second patient quote highlights that bothering the nurse for unnecessary things is not acceptable:

*you see the odd patient that is an absolute pest. It's nurse, nurse every 5 minutes for totally unnecessary things really... I mean you don't just shout on a nurse and take them away from what they're doing to come and do something stupid. Go and get you a tissue and bring it to you or something you know. You wait until somebody's free. Then if you want something like that you shout.*

*(Patient 17, female, age 72: 108)*



Patients who were experienced in the ward environment, who had an understanding of how ill they are and who could see patients who are in more need of help than them, saw their own care in the broader picture and became less demanding of the staff:

*There only thing I think of is that they are really, really kept going all the time and sometimes you have to wait a wee while before you get treated but it is only obvious that they have got I am not the only resident eh patient in this ward ken there are other patients and all that all I can think of apart from that ken they have been really excellent*

*(Patient 5, female, aged 57: 15)*

When asked about whether he felt that patients with CF were treated differently in the ward as they had a close rapport with nurses one patient responded:

*it sounds daft but in a, in a weird way it sort of works the other way, you know what I mean. They'll deal with them first and then they'll come and deal with us, because they know that we're fit and able do you ken what I mean. ... Half of the people that come on this ward are bed bound you know what I mean or they're really breathless ken what I mean. I mean fair enough we've got cystic fibrosis but it's no. It's no like we're dying the now, do you ken what I mean, although folk would say we're deteriorating and it is dying. But I mean we're able to walk to the. You know what I mean? We can walk to the shops and we can sit and talk to each other. I might have a sair heid but we're used to adapt. Our bodies adapt to the stress and strain of the CF right. So somebody that's come in who's no too well, you know, deal with them first. Get me later ken what I mean. I can hold off. I'll put oxygen on or something. So the nurses sort of, they dinnae. They'll deal with them first know what I mean and come. Unless we are, spewing up the blood and it's a case of look. Everybody needs. He needs help now ken what I mean. So I cannae see them being. If I just buzzed the now and says look could I get paracetamol? They'd quite easily say, can you wait 5 minutes till I deal with somebody? You know what I mean? They wouldnae go, oh you need paracetamol. Right, ken what I mean. We're no wrapped in cotton do you ken what I mean?*

*(Patient 25, male, age 21: 50)*

Seeing your own care in the wider context of the care of other patients on the ward and being aware of some of the institutional difficulties was indicative of more experienced patients' views. Patients who were excessively demanding and could not see their care in context were disapproved of by other patients who feel some allegiance with the



institution and its staff. This resulted in patients not wanting to make extra work for already overworked and busy staff.

Not disrupting the smooth running of the ward is one rule that not only patients but nurses do not like to be broken. This view is supported by May and Kelly (1982) who identified that nurses reacted negatively to patients who were too demanding. It is when this happens that patients clearly see nurses' positive and negative reactions to rule breaking. The extract below typified patients' views of nurses' negative reactions to disruptive behaviour:

*You can tell by the tone of their voices sometimes... the way they talk to them they say 'oh be quiet you are keeping everybody wakened' and things like that instead of talking nice to them and trying to comfort them at times eh. And sometimes humm You get a lot of them sitting in there saying oh if I could get my hand on that nurse I ken what I would dae to her for telling to that old woman like that and things like that so*

*(Patient 1, female, age 57: 112)*

The significance of patients seeing other patients being treated like this is indicated in this extract. It makes patients angry and it gives some indication of what patients value in their nursing care. This extract also indicates the power nurses have in chastising what they see as inappropriate behaviour. Patients want to challenge the nurses in this situation ('if I could get my hands on her'), although this does not appear to be a physical threat towards the nurse but a metaphorical one. This symbolises the idea that if patients had the power to do something about the situation, or if there were no repercussions to this challenge, they would confront nurses.

In contrast to this there were also incidences where the patient received comfort for their distress. This extract illustrates that nurses can, depending on their approach to patients, send signals to other patients about what is valued by nurses:

*yes they were awfully good with one person eh who I noted and she was always on about something eh but they were awfully good with her you know they never made any difference they never sort of oh this woman again sort of you know no no they gave her as much attention and that and were awfully good with her you know which I though was awfully nice*

*(Patient 7, female, age 82: 128-131)*

Patients saw that nurses dealt in a positive manner with patients who were seen as being difficult or disruptive. Treating patients like human beings and not treating difficult patients differently to other patients comes through strongly in the interviews. Treating patients as individuals and human beings and understanding their anxieties is key for patients in determining what good nursing care is and is addressed in Chapter Six: 'Recognising good nursing: actions, roles & values'.

Patients have expectations of other patients and nursing staff. Patients are expected to be tolerant, see their care in context and be prepared to wait for care if there are more needy patients. Patients should not be disruptive and demand excessive amounts of attention from overworked nursing staff. Nursing staff are expected to deal with patients as human beings and understand what it might be like to be in hospital and be ill and to make allowances for this. When patients see nurses respond negatively to an event such as the situation described involving elderly patients, conflict develops between patients and nurses, even though patients do not like other patients to be too demanding or disruptive. Ideally, nursing care, in the eyes of patients, should be non-judgemental and all patients should be treated the same regardless of the disruption they cause. Some of the nurses encountered by patients did not follow the rules or expectations that patients have of their nursing care.

#### PROBLEM PATIENTS: NURSES' RULES

Although patients set standards by which they judge other patients', and their own, behaviour, they identify that there are rules that are determined by the nursing staff. These rules and the consequences of breaking them can be seen when patients discuss problem patients. Rules are imposed to ensure that there is smooth running of the ward and that patients are compliant in their care. Problem patients are those patients who are not only disruptive to the smooth running of the ward but challenge nurses on aspects of care. Patients are not all passive recipients of care but do challenge, in their own way, the nurses on the ward. How successful these challenges are depends on how patients approach the nurses. Patients may challenge nurses, but within boundaries. In

developing their role as patient and gaining expertise in the environment, patients suggested that they developed ways of working with the nurses without upsetting them or being seen as difficult patients, which suggests there are consequences for patients who are seen as difficult:

*I try to set aside and no be cheeky but I will give her a sharp answer and leave it at that so she can sort it out herself*

*(Patient 8, male, age 80: 44-45)*

Not being cheeky to the nurses or reminding them ‘nicely’ (Patient 2, male, age 61:21) about things were strategies that patients used to keep on the good side of nurses.

### LIVING UP TO NURSES’ EXPECTATIONS: SOCIAL JUDGEMENT AND LEGITIMISING THE NURSE’S ROLE

Patient experiences highlighted that there are certain expectations that patients should live up to, as the quote earlier in the chapter supports. Patients should be passive, uncomplaining, be willing to change behaviour and compliant with the regime of care. Patients in the study did describe behaviour that was at odds with the professionally defined patient role in hospital. Patients in their description of events did seem to be aware that their behaviour is not what is expected of them. This awareness seems to have developed from observing the nurses’ reactions to behaviour:

*I have been stuck in my bed eh I am not allowed to get up out of my bed. If I go for a cigarette I get moaned at, well its my own fault really, I am meant to be on the suction anyway I am meant to be staying in my bed. But someone cannot stay in their bed for 24 hours a day.*

*(Patient 3, male, aged 27: 83)*

This patient indicated that he was ‘not allowed’ to get out of bed suggesting that a compliant patient in his condition would stay in bed. He was being treated for a respiratory complaint and therefore smoking would be a particular obstacle to his recovery. As a smoker he wished to have a cigarette, but as he described, he got ‘moaned at’ as he is seen to be not helping himself. He then blamed himself for

hampering his treatment, as the nurses did, even though he considered it unrealistic to stay in bed all of the time.

Patients therefore indicated that they know that something is expected of them. Some patients emphasised that they were being compliant and others indicated the response to them that they did not comply as the nurses expected, particularly when the nurses saw this as being a threat to their recovery. Phrases such as 'I am not allowed to' and 'they wouldnae let you' (patient 5) indicated the very directive and authoritarian manner in which nurses let patients know what is and is not acceptable. There does not seem to be much room for negotiation with the nurses.

This is reminiscent of the classic work by Parsons on the sick role (Parsons 1951). One of the central premises of Parsons' work is that sickness is not only sanctioned because of its biological basis but also because of the altered social status it brings. Parsons argues that illness is socially constructed and this is guided by the values of society (Porter 1998). Health care professionals authorise the sick role when an individual willingly seeks their help. The sick person displays deviant behaviours that are not normally acceptable in adults, such as dependence on others for basic personal care, and alongside this, the sick person is given a certain number of rights and privileges when he or she is ill (Nettleton 1995).

The sick person is not as such held responsible for his or her illness but must fulfil certain responsibilities when taking on the role. This supports the sick role as a passive one and the professional role as active. The sick person should want to get well and cooperate with health professionals in order to return to an improved state of health. Patients who have made an effort to get well are granted a certain social status and thus ill health can become part of the identity of the sufferer especially when living with a chronic illness. Not all individuals who are ill will seek professional help and therefore they will not access a professionally approved sick role. Accessing professional help may take some time and may not be dependent on the severity of symptoms but rather on the extent to which symptoms have meaning in an individual's life. Some symptoms

may be explained away but others may seem more significant to the individual and at this point professional help may be accessed (Nettleton 1995).

Friedson (1970) further develops the concept of the sick role and suggests that the extent to which an individual is granted the sick role is dependent on the legitimacy of the disease. Health care professionals draw on evidence other than physical symptoms in the legitimisation of the sick role, individuals with symptoms that are difficult to classify and variables such as age, gender, class and ethnicity influence the willingness of professionals to grant the sick role to individuals (Nettleton 1995). Friedson (1970) suggests that even though a patient may have been given the label of patient and assumed the sick role, he or she can still be held responsible for their illness. This has relevance in today's society where personal responsibility for one's health status is a key component of current health policy, although currently access to health care is not determined by how 'responsible' an individual is for their illness. Illness relating to drug misuse, smoking and communicable disease (particularly HIV related illness) are examples of illness where blame may be attached to a diagnosis. Therefore a complex social and cultural environment is the context in which individuals enter the sick role.

Patients learn about what kinds of patients and behaviour are valued by examining the care of others and their own care and treatment, as this next extract indicates. One patient made the assumption from the care he experienced that one of the unwritten rules of the ward was that some patients (in his case a drug user) should not be given the support that other patients are given because they are in some way responsible for their illness or not as deserving of care as other patients. Drug users are a group of patients who are often immediately considered to be difficult or unpopular patients, due to a diagnostic label they are given:

- P No I don't think that they bothered at all basically they... way I thought it was, well tough you were a drug user it's your problem you know*
- LC but you get a bit of a feeling that*
- P I wasn't being treated like I should be*
- LC so do you think that you got different treatment from nurses than other people did?*
- P not different I don't know I just thought that, basically they were thinking that oh well he is a drug user you know that was his problem not ours I don't know*

*(Patient 3, male, age 27: 78)*

This extract highlights that patients see that there is a hierarchy of patients and that some patients are viewed as less deserving of care than other patients. Patients particularly cited the confused elderly as patients least valued and most disempowered in the ward environment, and this is supported by research evidence (Johnson and Webb 1995a; Koch and Webb 1996). There is much support from research studies that there are some groups of patients that are stigmatised because of their diagnosis. Patients with psychiatric diagnoses, Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) related illnesses and drug users are amongst some of the most stigmatised groups of patients (McCann and Sharkey 1998). Before even meeting patients with stigmatising diagnoses or behaviours, nurses can have already labelled them as difficult.

There also was an expectation from nurses that patients would fit into a 'one size fits all' regime of care. The expectation that patients would recover after a certain length of time, for example, would be out of bed or walking on prescribed days was evident. This is exemplified in the following extracts from an interview. This patient described the expectations of nurses regarding the amount of pain control he needed:



*if I am in pain during the day they give you paracetamol which is ... that is nothing to me eh as I am already on a strong pain killer and it's not doing its job so eh what's the good or paracetamol it's no good it just doesnae work...I have already told I don't know how many times to tell them [the doctors] that the paracetamol don't work and they keep saying well maist operations nowadays major operations like, paracetamol is the thing that they give you eh. But I just didnae find that it was doing anything at all.*

*(Patient 3, male, aged 27: 174)*

This patient felt that he was being punished by not having adequate pain control for repeatedly breaking the rules and for being a drug user, which he felt was not taken into consideration in his care. Pain is the subject of much nursing and medical research and ensuring the best pain control possible is a central feature of nursing practice. It is the responsibility of the nurse to administer prescribed medication to the patient and the nurse may be involved in implementing other (non-pharmacological) techniques that may assist pain control. Core textbooks for pre-registration nursing education (for example Alexander *et al* (2000) and Walsh 2002) devote chapters to nursing management of pain, encouraging the nurse to look at pain from the perspective of the patient and to understand that pain is more than just a physiological concept.

Salmon and Manyande (1996) examined why patients seemed to get less analgesics post-operatively than they actually need. Much research in this area has focused on nurses' attitudes towards analgesia and their ability to assess pain (Salmon and Manyande 1996). Salmon and Manyande's (1996) research focused on an alternative view of under-medication. Their hypothesis was that patients do not inform nurses about their difficulties in coping with pain because of their fear that this would lead to disapproval from nurses. Nurses, therefore, may overestimate coping and underestimate the patient's need for analgesia. More importantly the researchers suggest that patients who do not appear to cope well with pain or appear distressed because of pain, or are seen in this way by the nurses, will be branded unpopular and are therefore subject to the same 'punishment' as other unpopular patients.

This seems to be this particular patient's experience of nursing care of his pain. He repeatedly asked the nurses to request that a stronger analgesic be prescribed. The nurses



did not refuse but seemed to dismiss him by telling him that most operations only require paracetamol for pain control. He tried to explain to the nurses that as he was on a high dose of opiate maintenance medication for his addiction, paracetamol would not help him. This patient went on to suggest that it was because of his drug problem that this happened and he felt that the nurses held him responsible for his illness and did not seem to feel that he deserved the care. This patient called into question the authority and the ability of the nurses and to some extent he seems to feel he has paid a price for it. Further on in the interview he began to talk about becoming less compliant, as he started to refuse analgesics because they didn't work. It is not clear if the nurses in question did ask the doctors to review his prescription but the patient's impression was that these nurses dismissed his view and did not care for him. Anxiety and distress can lead to a heightened experience of pain and it is clear that these nurses did not attempt to alleviate his anxiety but isolated him and viewed him with suspicion. For a time at least he was displaying many of the features of the unpopular or difficult patient. He came from a group (drug users) that is viewed suspiciously and is already stigmatised; he was not making attempts to get himself better (by smoking) and was challenging the authority of the nurses about his pain control.

There are claims that Parsons' theory was developed in a culturally bound middle class American group in the 1950s and may have limited relevance for health care today. This work has certainly been a foundation of a number of studies of patient and health personnel roles utilising different methodological and epistemological standpoints and does still seem to have some current relevance to health care in the UK, as the current research will indicate. Parsons and Friedson construct the sick role in a structural functionalist paradigm, when role and function are determined by a set of rules and laws (Nettleton 1995). This has been critiqued as a limitation to the use of the sick role theory by Porter (1998). However, Kelly and May (1982) argue that Parsons' work on the sick role has been extracted from its original work and has been examined in isolation. The work has been criticised for taking a structuralist, fixed view of role, omitting to take into consideration the influence of social interaction on role (Kelly and May 1982). They

suggest that Parsons' interest in fact was primarily in the medical role and not the patient's role and that Parson failed to acknowledge that roles develop as individuals interact with each other. Kelly and May (1982) argue that there is a tendency for nursing literature to only look at roles in a fixed structuralist way and not examine the interactionist perspective in the development of roles for individuals.

Parsons' analysis assumes that there is consensus within the social system (Porter 1998). It is clear from the conversations with patients that this consensus was not always reached and some patients did try to have their voice heard in care. A structuralist perspective does not fully account for power and inequality in the relationships between patients and nurses.

Patient challenges that are not seen as a threat to nurses, such as reminding them nicely, not being cheeky but giving a sharp answer may be acceptable. Pushing the boundaries of this to challenging the knowledge and status of nurses or to suggest that the nurse's ability is in question may not be resolved well, as the next extract illustrates:

*I take quite a lot of interest in what's happened to me and a couple of weeks ago I found a bit on the internet questioning the safety of Epo [a drug used in dialysis] and I brought it up with [name of nurse] and you know she was saying. Ah rubbish. It's fine. It's ok. And on the internet it actually said that it should be given through the machine. And I said this to her and she was like. No no, you know it's ok. And then about 2 weeks later we've all started getting it through our machine. I don't think it's because of anything I said. I think it's obviously come from you know, somewhere else. But I wasn't, you know making it up or, and it was a valid point you know. And I said to someone, why are we getting it through the machine? And they said, oh it's better for you and that was it.*

*(Patient 21, female, age 28: 88)*

May and Kelly (1982) examine the phenomena of patients challenging the authority and therapeutic competence of nurses. Although this research focuses on the mental health setting where the authors consider challenges to authority and competence to be compounded by nursing work that is less supported by technology and tasks, the research does have some relevance to the adult health setting. The observational and interview data they collected categorises some patients as bad or difficult. Nurses

commented on the behaviour of a patient in a way that served to 'reaffirm their own personal and professional value, and reinforce the functional solidarity of the group' (May and Kelly 1982: 280 *et seq*). This is seen in the extract below when a patient talked about looking at his charts at the bottom of his bed. This man used to be a biologist and could interpret the readings marked on his chart:

*I did have words one time with the ward sister of looking at my blood pressure chart and she made a bit song and dance in front of the, the medical rounds saying. Oh do you know what it is they actually stand for and I told her. And she came back and told me under no circumstances was I to ever look at my blood charts again. Rightly or wrongly I mean. I have no problem with that. It's no great secret and I mean you're only looking at trends basically. So I mean I'm, I wasn't giving any secrets away and I'm not, I don't look at anybody else's blood charts by any stretch of the imagination. I'd be too, too naïve to do that. But my own, my own information is, I will ask for it first and if not, I will, I wouldn't say by hook or crook get it, but I will, I will ask.*

*(Patient 14, male, age 52: 69)*

Problem patients are those who threaten, explicitly or implicitly, the authority of nurses and are often subject to repercussions from nursing staff, such as having their requests ignored and having rules enforced. As highlighted in the extracts above, control of information is one recognised way in which nurses maintain power imbalance (Sinivaara *et al* 2004).

The research by Stockwell (Stockwell 1972), which was based on Parsons' work, identifies the unpopular patient as displaying behaviour that essentially is not in keeping with the sick role (Porter 1998). Stockwell searched for rules and laws that made a patient unpopular. This research, and work based on it, has since been critiqued for utilising predetermined scales and ill-defined terms and, as with other structuralist approaches, being simplistic and not taking into account social factors or interactions in the labelling of patients (Kelly and May 1982). These studies suggest that particular groups of patients with certain diagnoses, illnesses or social factors may be classed as unpopular. Nurses use sanctions to try to punish or rectify patient's behaviour by ignoring the patients, forgetting requests, enforcing rules and using sarcasm. Conversely

‘good’ patients are rewarded with more time and personalised interaction and being allowed to bend the rules.

In their review of the literature on good and bad patients, Kelly and May (1982) indicate that there is much inconsistency in the literature on what constitutes a good or bad patient, leading to difficulty in generalising findings. This may be because laws and generalisations cannot prescribe role in complex social settings. Nurse and patient roles may only have meaning or be understood in their interaction with one another (Kelly and May 1982). Kelly and May (1982) consider that instead it may be how patients provide or withhold the legitimisation of the nurse’s role that make a patient popular or unpopular. This was evident in the data presented in this thesis.

Johnson and Webb (1995b) favour the concept of social judgement in viewing unpopular patients. Their ethnographic study supports the view that evaluative labels about patients are not ‘in any way predictable’ (Johnson and Webb 1995b: 466) and labels can be negotiated. Nurses in this study did interact differently with patients depending on how they were viewed, although nurses attempted to give high quality care to all patients and expressed guilt about the way some patients were labelled. Johnson and Webb (1995b) present social judgement as a re-conception of a way to re-examine the unpopular patient. Social judgment plays a significant part in staff making moral decisions about patient being good or bad or how nurses judge the worth of patients.

They argue that:

Social evaluations are not in any way tied to traits or variables which patients do or do not possess. Rather, evaluations of people in the ward were socially constructed in relation to a complex web of powerful social influences. Key threads in the web are power, status, the management of uncertainty and negotiation, through which evaluative labels become flexible and changeable, depending on the social context.

(Johnson and Webb 1995b: 471)

The extracts above are situations where patients were taking an active interest in their care and treatment, which was not received positively by nurses. Involving patients actively in their care is one of the central tenets of policy directives in the UK health

service and this has also been identified as an international phenomenon (Gallant *et al* 2002).

## CARE BY THE BOOK

When talking to patients it became apparent that some nurses were less flexible than others in care. These were nurses who gave care 'by the book' - they gave care as they thought it should be rather than listening to what the patients wanted. In this first extract this patient with cystic fibrosis (CF) talked about what happened when agency nurses were employed in the ward when there were staff shortages. These nurses were seen as doing things by the book because they did not know the patients well and did not understand that CF patients worked differently in the ward environment.

*They do everything by the book. They don't know the way that the CF work. Like we've been here that often, the other nurses know us.*

*(Patient 24, male, age 23: 8)*

Care by the book is nursing care that is seen as inflexible. However, the comments of two patients with diabetes who both talked about care by the book contrast this view. The first extract suggests that care by the book is nursing care that does not recognise your independence and the second that it does not recognise that patients sometimes want to be dependent on staff for care:

*Generally the nursing care has been alright. Obviously you'll appreciate with being diabetic there's, when I'm at home, by myself I've got to get on, check myself, monitor myself, go do the shopping, make sure I've got the right food in for the right circumstances. A lot of that does get taken away from you while you're in hospital. Most of the staff as such will take that on board. Although there are, there can be one or two who go by the book so to speak.*

*(Patient 14, male, age 52: 3)*

*the nurses that play it by the book tend to be more of a problem, mainly because you're diabetic, it's your problem, you look after it. Obviously when I'm at home I inject twice a day. I inject into my leg. I have no problem with that. If I did I would be in the hospital far more often with much more greater complications than I am. Recently there's been one nurse who said there's your insulin. Take it. Well, just now what I can do is, if you [the nurse] inject it into my arms, that's giving my usual site a rest. That's not the point. If you were at home you would inject. If I was at home I wouldn't be in hospital. Both myself and the nurse had valid points, but at the same time it was very much you'll do what I say, because I know more than you do, which rightly or wrongly wouldn't be right.*

*(Patient 12, male, age 55: 5)*

As can be seen from these two extracts there is no book that says what the care should be, but care by the book is seen as any care that is seen as rigid and not negotiated in partnership with the individual patient.

## COMPLYING WITH CARE

One of the main sources of tension between nurses and patients in the hospital was complying with care regimes. Patients who did not comply found themselves stigmatised as unpopular and difficult by nurses, this was also described by May and Kelly (1982) who identified this as lack of 'commitment to therapy'. One patient was regularly in confrontation with nursing staff about smoking. Like the patient experience described above, nurses seemed to consider that this patient was hampering her recovery by smoking. She discussed the nurse's response to her smoking:

*'You can either have your cigarettes or the oxygen cause there's no point in having oxygen if you have cigarettes'. So I says, fine I'll just have my cigarettes... mean she just left me with no oxygen. But um, I just want to get home you know, to normal...I mean last time when I was so ill that well every time I coughed I couldn't stop and I threw up. When I passed I heard her saying. If she didn't smoke she wouldn't have that cough.*

*(Patient 11, female, age 35: 38 & 72)*

It is clear from the nurse's comments that she did not approve and to 'punish' this patient her oxygen was removed. This patient then went on to say that this had not changed her behaviour and the disapproving comments continued:



*I've done, done it once too often, wandered off without telling somebody so. One of the other staff nurses came in. She had brought me medication cause I had a sore head. That's why I went to sleep because I had a headache. I lay down and eventually fell asleep. And she says. I says look can I have my medication? She says I brought it in and you weren't there. She says if you're well enough to go out and smoke you must be feeling a bit better. So I says right. She says well do you want one? I says no. I don't. Well I heard her say to [name of nurse]. It's the 12 year old then. So, I just you know, carried on doing my own thing. And I had been out smoking when somebody from the renal I think it was, or either that or the insulin injection were coming around and they says you know we were looking for you. I says yeah I was out behaving like a 12 year old.*

*(Patient 11, female, age 35: 6)*

This patient described using smoking as her way of coping with the uncertainty of her health. She was a young woman with a number of serious health problems. She knew she couldn't give up smoking with the stress she was under but eventually tried to incorporate it with the ward routine:

*I've been out having a cigarette while she's been pulling up my injection. But no I mean, I try and work out when I'm not going to be getting my injection or my thumb pricked. If I have a cigarette, I try and work out the times. I used to have a diabetic opposite me. She was quite good at telling me.*

*(Patient 11, female, age 35: 90)*

Other patients also discussed taking responsibility for changing behaviour to comply with nurses' expectations, for example, bearing pain and discomfort in procedures and learning how to negotiate with nurses in a manner to which they would respond more favourably. Patients became more compliant to improve their relationship with nurses or appeared more compliant to the nurses by stopping complaining or asking questions. This seemed to be the only option for some patients.

Compliance with care and treatment plans has been identified as a powerful tool for maintaining power relations with patients (Playle and Keely 1998). It has been defined simply as 'patients doing what health professionals want them to do' (Fletcher 1989: 453). A significant proportion of the nursing literature describes non-compliance as a problem needing to be solved without acknowledging the factors that may lead a patient



to not comply with treatment or care plans (Russell *et al* 2003). Although the language surrounding compliance has changed from 'compliance' to 'adherence' to 'concordance', to reflect care that is negotiated with the patient, it has been argued the values behind have not changed and that compliance with care, or more importantly non-compliance with care, is seen as problematic as it:

contravenes professional beliefs, norms and expectations regarding the 'proper' roles of patients and professionals (Playle and Keely 1998: 304).

At one level compliance with care is a method of improving health and the effectiveness of health care, but at a covert level it can be seen as reflecting professional control and power. Implicit in compliance is the setting up of the role of an 'expert' who gives advice to the lay person (Playle and Keely 1998). Patients who are non-compliant are labelled as deviant and stigmatised by nurses.

Patients are considered to have a reciprocal role with health professionals. The nurse's role is to care for and treat the patient. The patient's role is to be compliant with this and take on the responsibility of compliant behaviour. This view of patients as passive with professionals holding legitimate power and knowledge is what Becker *et al* (1961) calls 'hierarchy of credibility'; this hierarchy has patients at the bottom.

## **Negotiating care**

Although there were circumstances in which it was clear to patients that social judgement and legitimisation of the nurse's role were the basis of the power relationship between nurses and patients, there were other instances in which patients identified a different approach to patients. Negotiating care is a category that helps to clarify and gives some conditions where nurses' rules were not the foundation of the nurse/patient relationship.

Some patients did try to negotiate with nurses about some aspects of their care, particularly patients who used hospitalisation as a break from the responsibility of

illness. Being able to be flexible with the rules, not giving care by the book and listening to patients were all valued by patients:

*they take the knowledge, you know the fact that you do look after yourself. I mean they'll come up and say you know, what insulin do you think you should take tonight? You know, this is your blood sugar. That sort of thing. When they do take my blood glucose I always ask what it is, so I've got an idea myself, what's going on. I don't really so much say that you know, that should be so much insulin I should be taking. But I am aware of what's going on and you know sort of what I am getting.*

*(Patient 14, male, age 52: 5)*

The clearest examples of this were with the patients with CF, although a number of patients talked about nurses going out of their way to care for patients. These CF patients are an unusual group. They are young but seriously ill and without a lung transplant they will be likely to die before the age of thirty. These patients have had regular contact with the health service since early childhood and regularly are inpatients in the hospital in one particular ward. All of these factors seem to add together to allow nurses greater flexibility in care. One of the best examples of this is that patients are permitted to leave the ward and visit pubs and drink if they want, which is in sharp contrast to patients who could not leave the ward for a cigarette:

*I think it's awright. It's good. I think cause like they know us like so well, like em, trying to think. Like they let us get away with things. Like we'll go out and like say go for a drink and we come in and like as long as you're no coming in like drunk and if your singing songs and skipping up the .... And that. I mean they dinnae mind us going out for a wee drink and. They let us get out and things like that so it's quite good.*

*(Patient 22, male, age 20: 4)*

A number of other special dispensations were made for the CF patients that would not have been made for other patients in the ward:

*I think, I think we could get away with murder in here. Well not murder [food served] Like we all sit here with our mobiles on. Yeah well we get a row downstairs, but as long as we're in our rooms and sort of keep it a bit hush-hush then. I mean obviously we're not allowed to walk around the corridors, talking on the mobiles but. And em, we get a lot of like takeaways delivered to the ward as well. I don't know whether that happens anywhere else...But we can get pizzas and Chinesees delivered to our rooms. Em, I think that's also to do with us putting on weight as well. Cause they want us to put on weight, they let us order food. Em, but I think, and we can go out as well, come back quite late.*

*(Patient 26, male, age 20: 80)*

Patients and nurses justified some of the 'privileges' by saying they were important for the patient's care, such as putting on weight. Different aspects of care were also negotiated with the nurses, particularly intravenous medication. Patients negotiated on a daily basis whether they wanted to give their own medication or whether the nurses should do it. Patients considered that this give and take over care was also viewed as positive by nurses as it allowed patients to have some breathing space and give them more energy to go out and live their lives. The breaking of rules was justified as it had a therapeutic benefit.

## **Patients' work**

It has already been alluded to earlier in the chapter that patients described aspects of their illness as work; this category developed from patients' experiences of dealing with their illness and hospitalisation. The patients in this study had sought assistance for their problem (or were forced to by the acute nature of their illness) and they had remained in hospital for care and treatment. During our conversations patients did indicate that there was some element of cooperation with care, with fulfilling the role of a compliant patient. Some patients expressed relief at coming into hospital and were grateful for the care received, a prerequisite for the good patient. Not only should a patient actively want and value care, they must take an active part in their recovery. The patients below indicated that they were trying to 'help' with their care by not being a 'bother' (Patient 8, male, age 80: 220) to the nurses and managing as much as they could themselves:

*cos this is the only time I have really had help....other times I have always insisted that I would dae it myself, [laughs] this time I was too knackered.*

*(Patient 1, female, age 57: 822)*

The quotes are indicative of patients who wanted to save the nurses unnecessary work, or want to try to complete basic personal tasks unless they are actually not able to do them. Patients are initially unsure about how they should behave when they arrive on the ward particularly if they have no prior experience of being a patient. Some patients did not characterise their hospital experience as one that they were actively part of. This was indicated in the patients' willingness to cooperate with and trust the nurses and to believe that what they were doing was the best for them: 'they are all standing waiting to help you right at your beck and call and they canny do enough for you' (Patient 4, male, age 58: 5).

Learning to suffer and accept pain can be seen as a kind of work that patients have to undertake as well as the emotional work of coming to terms with a serious or life changing illness. Strauss *et al* (1982) examine patients' participation in their own care conceptualising this as patients' work. They suggest that to see patients' efforts in their own care merely as cooperation does not acknowledge patients' work.

Patients' work may be acknowledged by nursing staff as 'explicit' (Strauss *et al* 1982) work and in fact may give patients work to do. For example, patients may take an active part in monitoring their condition or in teaching prior to discharge. This seemed to be of particular note amongst patients in the renal unit. These patients were expected to learn procedures and assist the nurses, for example laying out sterile packs for the nurses at their bedside:

*They [the nurses] do very little. The fact is we're all healthy here you see and they take that, they take advantage of that you know. And so they expect you to do as much as you can do. I mean if my, see if my machine goes off you know what's wrong with it and you just try and correct it. If you can't correct it then obviously you have to call them over and just leave it blowing you know.*

*(Patient 20, female, age 41: 70)*

This role in assisting nurses often leads to grey areas in care where it is not clear who is responsible for ensuring care is carried out to an appropriate standard:

*Yeah. I suppose it really only affects the dialysis unit because, because we're reasonably experienced in our care, we assume a certain amount of responsibility for the care. But there is the grey area. I mean there's an interesting grey area in the, giving out the eprex. Now the nurse will get it from the fridge, but she'll then leave it on your tray and you will inject it. So if you were to look at the drugs chart, you'll see numbers of weeks that aren't signed for. OK? So I mean I'm injecting the eprex but, who's responsible for signing it? You know, that's the sort of. You know they're not huge grey areas, but you know we're talking about medication being issued that sometimes quite often isn't being signed for.*

*(Patient 19, male, age 40: 54)*

However, much patient work does go unrecognised as 'implicit' (Strauss *et al* 1982) work and is taken for granted. Examples include personal hygiene, feeding oneself, cooperating during often uncomfortable tests and procedures, fitting into the ward and giving information to staff:

*You know, I was new patient and I didn't, I felt like I wasn't introduced to people, wasn't introduced to nurses, wasn't introduced to anybody I dialysed with. I had to do all that myself. But luckily I've got the personality and the confidence to do that, but not everybody can you know.*

*(Patient 21, female, age 28: 10)*

Patients are often expected to bear pain and discomfort silently and with self-control. Patients who do not behave as expected will build up a negative reputation. Reluctant patients may be the subject of demands from nursing staff and punished if they do not carry out the work that is expected of them. Patients may also be invited to undertake some work. This may be because the nurse is too busy or because the nurse feels that the patient would benefit in some way from undertaking the work themselves.

## **Understanding the role of the nurse**

As the role of the patient is socially constructed, and interactions with nurses and fellow patients determine the patient role, it is clear that the role of the nurse is also constructed in this way. From the discussion above it is possible to see that patients involved in this

study presented a complex picture of nursing. Sometimes it was caring, with nurses going out of their way for patients. At times, nurses were identified as being unsympathetic and standing in judgement of behaviour. The interaction between the patient and the nurse defines whether the nurse is seen as good and bad in the same way as the patient is seen as good and bad by the nurse.

In general patients described good nurses as having special characteristics: patient, cheerful or 'angels' (Patient 6, female, aged 63: 23). For example:

*aye as I say it takes a special girl for tae dae what they dae*

*(Patient 4, male, age 58: 157)*

Patients come into hospital with expectations of nurses and nursing work, and this will be more fully discussed in the next chapter.

#### 'MUCKING IN' – THE SCOPE OF NURSING PRACTICE

The role of the nurse in the hospital was difficult for patients to understand clearly. Patients were able to identify different grades of nurse on the ward and the fact that there was a hierarchy with everyone able to do their own bit. Patients recognised that there was a hierarchy in the ward and that a coordination of roles was necessary to get the work done:

*they all had their own level and they were sticking to their own level and jobs you see for people who hadn't been nurses for so long and that sort of thing and they all had their own jobs and and the one in charge eh everyday and they all had their little bit of paper in their pockets with what they had got to do and they went and did it you know*

*(Patient 7, female, age 82: 133)*

This extract suggests something about the organisation of nursing work in the ward. It is clear from this extract that there is a hierarchy, there is leadership and work is divided up amongst the staff and they work to their own level. But there was a recognition that nurses would have to be flexible in tasks that they did:



*Aye yeah they are doing the sort of menial tasks you often hear shouting on another nurse come and gie me a hand with this patient and they put the curtains round and that and eh its eh they dirty their hands they do you know they just all sort eh muck in about you know there is not a class system no and they talk to the other junior nurses and the menial staff just eh... what do you call it the are no eh there is no class system they all talk together and everything aye.*

*(Patient 4, male, age 58: 185)*

Patients seemed to be impressed that there was not a class system, that all nurses did dirty work, or what was referred to as 'mucking in'. Patients considered that work with the body, particularly washing and dealing with bodily fluids, cleaning up, making beds and giving out meals to be low level tasks. In nursing work, body tasks, or dirty tasks, are seen as the more basic or fundamental skills in the hierarchy, with nursing work seeming to progress from this focus on the body to highly technical work that is highly medicalised and depersonalised (Lawler 1991). Traditionally, increasing experience and seniority allowed nurses to move from undertaking basic tasks, which have the least status, to more technical tasks. Patients understand nursing work in a similar way to this. What is not clear however is if patients learn this from their experience of nursing or whether it relates to the way in which bodily functions are regarded by our society.

The mystification of nursing work was explained by a patient on renal dialysis. Patients are consumed into the machine of care and what is happening is not fully explained to the patient. This patient said it took him two years to work out what the right questions to ask about his care were:

*Yeah I think so. You know, I think there should be a certain amount of information given out to patients, especially in dialysis. But I think the problem you run into here, as I was telling you, the conveyor belt situation. But the problem you get in here is really sort of like familiarity. You know it's repetitive procedures over and over you know, and I think they quite often find it hard to distinguish you know, a patient who's only just done his like first or second dialysis, to one who's been doing it for 3 years. You know you quite, you're almost consumed into the machine straight away you know. you know I suppose after about 2 years you know what to ask and why they're doing this and why they're not...*

*(Patient 19, male, age 40: 18)*



Conversations with patients indicated that they found it difficult to express clearly what nurses do. As a result, they described nursing in a general way, as nurses 'just doing what they do'. This reflects to some extent the fact that the kind of caring work that nurses do has never been clearly conceptualised. Nursing work takes its theoretical base from a number of disciplines and nurses themselves have difficulty in expressing analytically or otherwise some of the 'invisible work' of nursing (Davis 1995). Beyond describing tasks that nurses do, patients found it difficult to articulate what nursing work is:

*Yes it is no just one particular thing eh that sticks out as it is their everyday work again they cannie dae enough for you they would do anything aye...what they do and they do it to their best ability I think so I cannie just put my finger on certain things.*

*(Patient 4, male, age 58: 41)*

When patients described nurses attending to them this was often associated with meeting patient needs, for example, if a patient had rung the buzzer for something. As much of nursing work is body work, it may be that this has been mystified as in contemporary society body work is in the private sphere. It may be that only when individuals need nursing care do they have intimate contact with another person and so may have little experience of what is happening and how to express this. Although these tasks may be seen as low in the hierarchy of nursing work, patients did indicate that they were very important to them:

*...and you want a wash and they give you this wash and honestly it really feels great eh it is marvellous or a bath if they can get you in the bath or something it's super you know that is very important.*

*(Patient 2, male, age 61: 157)*

Participants suggested that the nurses talk to each other and negotiate their work and ask others to help them when they need it. What is more, the nature of nurses' work means that anyone may have to answer a buzzer or attend to a patient as the immediate needs of the patient outweigh the need for divisive skill mix:

*cos I mean if somebody buzz you dinnae really ken what they are buzzing for so a nurse a staff nurse anybody will come it could be a commode you would say no that but they have got to come if there is nobody else eh.*

*(Patient 1, female, age 57: 282)*

Skill mix then may be possible and desirable with more routine or menial work, or for legal reasons, for example the administration of medication. However, at some point everyone has to 'muck in' to meet the needs of patients and this suggests the need in the ward environment not just for skill mix but also for teamwork. Davis (1995) identifies that the scope of nursing practice has to be flexible in order to meet patients' needs and there is thus the 'sheer impossibility of rigid job demarcations when the paramount issue is to remain alert to the needs of others' (Davis 1995:22).

This 'mucking in' did raise some questions for patients about whether this range of work from the menial tasks such as giving out food and give highly technical care were incompatible:

*Yeah I'm sort of like ... aspect of nursing. Having seen it in operation in wards and in you know, in the [Renal Unit] as well, I think they're somehow stuck in the middle. In other professions you tend to know where your boundaries are and where they aren't. The nurses are generally asked to do everything you know as. I've got experience in civil engineering you know, and you're either staff or you're on the labour force. Nurses seem to be stuck in the middle somewhere. They're neither technical staff nor labour force. They tend to do what I would regard as labouring jobs but they're also asked to be technically experienced as well you know. and I think that's probably an issue for nursing in general, whether or not they gonna go down the road of maybe splitting nursing into say nursing assistants or care assistants or whatever and actual clinical nurses you know. Cause you see nurses in here do quite a lot of what I would regard as labouring work you know. Serving tea and toast, making beds you know. Stripping the machines can actually be quite hard work you know. Now whether or not you need a professionally trained nurse to actually do that when you could be paying someone else to do it. But I suppose that's a slightly different subject... Yeah I mean it can undermine your confidence a little, is that if you see a nurse responsible for your medication, also responsible for delivering you soup you know. I don't know, maybe as a patient that can undermine your confidence a little, possibly you know. I can't fully explain why I said that but you know...*

*(Patient 19, male, age 40: 112)*

This view was shared by a number of patients:

*...I think sometimes that very skilled people...I will use the word demean by doing things they don't have to do in the ward it could be maybe nursing in inverted commas more you know i.e. changing beds blah blah blah serving up meals you know they could be at their nursing in their nursing mode all the time... nurses nursing is more profitable although it is nice to see nurses serving up the meal but I can't see it as one of their tasks as a nurse... unless it is a dietary thing or you know...*

*(Patient 2, male, age 61: 442)*

These examples indicate that nurses are 'stuck in the middle': neither on the staff or in the labour force. This can make it difficult for patients to reconcile seeing nurses who are highly skilled and educated serving soup to patients. Patients do not see the complex assessment and nursing care that goes on behind these 'basic' tasks. For example whilst bathing a patient a qualified nurse might also be assessing wounds, mobility, skin integrity, cognitive ability and suitability for discharge, or assessing dietary intake whilst serving food. This suggests that some nursing work is invisible to patients, possibly because it is not articulated to patients as a highly skilled procedure.

## THE PLACE OF NURSES IN THE INSTITUTION

When interviewing patients about their nursing care, patients frequently discussed the position of nurses in the hierarchy. This theme developed from elements of the interviews where patients compared nurses to the medical profession. It is interesting that doctors were the only health care professionals other than nurses that were discussed by participants. This may suggest that doctors are seen as more closely linked with nurses than other health care professions and this is supported by patients' observations of the hierarchy of relationships between doctors and nurses. An example of this arose when a patient indicated that it was difficult for nurses to give any specific opinions about care or treatment as the medical staff were seen to have the last say in these matters:

*Obviously they [the nurses] don't have any specific opinions on my condition or anything else but they have to keep it open ended because the doctors have got their opinions at the end eh.*

*(Patient 2, male, age 61: 145)*

This gives some indication that nurses are seen to have less power in the decision making process and are unable to give specific information about patients' conditions, deferring to the opinion of doctors.

It is also probable that patients are not party to debates on clinical management that involves the care team, as these may not happen at the bedside. Patients are informed about clinical decisions at the ward round, which in the research site (a traditional teaching hospital) is dominated by medical staff. It is possible that nursing decisions on care management are seen as day to day and go unnoticed as they may not be as visible to the patient as medical decisions, such as making a differential diagnosis. Nurses' decision-making goes unnoticed as they are not associated with the rituals involved in the ward round. This was alluded to by one patient, emphasising the issue of invisible nursing skills such as assessment and decision making. Nurses are not articulating this to patients:

*When the doctors come round on their rounds it is usually one of the staff nurses accompany them but eh she is just there maybe if the doctor asks her a question like eh... she is always there.... To ... I suppose they will probably have private conversations before they go into the ward just going over what they are going to say about the patient and that you know I think that anyway cos they are all well clued up when they come in.*

*(Patient 4, male, age 58: 197)*

Patients viewed nurses as quite disempowered in the hospital situation. They talked about them working long hours, being under pressure, doing their best in a situation and not being in a position of decision making:

*P Yeah I would say so. I think the pressure is such and I think the problem is that the nursing staff in here probably don't believe that they can change things either.*

*LC Change the way the system works here you mean?*

*P Absolutely. You know I think they've probably got quite a lot to say, but whether or not they can influence things in this department or not, I don't know.*

*(Patient 19, male, age 40: 75)*

Not only were nurses seen as disempowered by their environment and working with a more 'powerful' profession, they were not considered as being able to change the situation.

Nurses seemed to fulfil a different role to medical staff regarding what kind of information nurses give to patients about their condition and care. As was indicated earlier, patients see the nurse's role in communication as interpreting information for the individual. Therefore nurses and doctors give different views of the same subject matter. Information given by doctors is seen as more technical and difficult to understand and the nurses will then tell the patient what they were really talking about:

*Well the doctors talk over your head and when they go away you ask the nurse and she will tell you just what they were on about ken....: aye well if there is something you are not sure of they are keeping you right eh cos I mean sometimes the doctors will tell you something and you are sitting, right aye and once he goes away and you will think well what does he actually just mean there so if you get the nurse back she can tell you.*

*(Patient 1, female, age 57: 438)*

The issue of what kind of information is given is contrasted with access to information. This participant again illustrated this point. When asked whether she felt differently about asking nurses questions, she responded that she did not, but the answer was different as the answer was less 'technical':

*LC Right so you feel differently about asking nurses questions than you would feel if you were to ask a doctor questions?*

*P No, but they put it to you better ken they are not so technical, is that what the word would be.*

*(Patient 1, female, age 57: 438)*

This indicates that nurses were not necessarily seen as more or less approachable, but that the information when given was at a more acceptable level to the patient. Not only did dissemination of information from nurses seem less technical to patients, nurses were seen to have a less mechanical or technical focus to their work when compared to medical staff:

*other times it is a bit, the doctors seem to be a bit more, let's get this blood sample ....*

*(Patient 2, male, age 61: 81)*

This indicates that nurses have a different approach to their work. This less technical approach enhanced relationships between nursing staff and patients and allowed patients to feel that they were being cared for as individuals rather than being treated as an object. This was very important to patients.

#### UNDERSTANDING AT THE EXTREMES OF CARE

As has already been indicated, patients did have difficulty in articulating what nurses actually did beyond the performance of specific tasks. There were times however during interviews with patients when they seemed to have a clearer understanding about what was happening in a patient/nurse encounter. It was at the extremes of ability, the bad and the good, that patients were able to articulate what nurses could do or do not do. The central aspect of what makes an interaction bad or good is caring behaviours that nurses display.

This is illustrated by patients' descriptions of incidents of care that they did not find satisfactory. Although these extracts are numerous and lengthy, they do emphasise the impact of experiences on patients and that they learned a great deal about nursing from them.

This first extract illustrates the patient's need for someone to listen to them and to acknowledge that she is an expert in the care of her chronic condition:



*Well I am diabetic and they are supposed to come and see to my insulin the amount of times that I have got to ask for insulin and things like that ken, but when you are first brought in oh they are there doing your bm and getting your insulin for you.... cos I am supposed to get it before breakfast and some times it is after breakfast and they will say och it doesn't matter you can have it half an hour after you have eaten but that is not the way I do it ken so things like that.*

*(Patient 1, female, age 57: 32)*

The patient in this extract wanted the nurses to acknowledge the way in which she managed her medication at home. Patients do acknowledge the need for routine, as there are a number of patients with different needs on the ward, but that this should not undermine their own control over their condition. The nurses did not facilitate this patient taking control over her diabetes in hospital nor did they give a satisfactory explanation of why care had to be so different in the ward. This powerlessness over care is also apparent in the next extract when a patient repeatedly asked for medication he knew he had brought into hospital with him. The nurses did not respond to his request and have his medication collected from another ward even though he expressed concern about the impact this would have on his health. The patient then talked about the nurses on the third night 'making the effort right away'. There is a sense that the patient wanted the nurses to take him and his concerns seriously:

*Just for the day and they moved me here now I knew the hadnae moved my eh em box of drugs which I had brought from home....and I mentioned it maybe five times, four or five times, because I knew there were drugs in there they they didn't have eventually I went two nights without the drug and I needed it but I knew it was in that box 'oh right we will have to get that up, we will have to get that up here. So it wasnie until the third, last night that em the night nurse, sorry the nursing staff on at night em they made an effort right away' oh we had better phone them, and get this box up and see what you have got' so I got my drug back then [laughs].*

*(Patient 2, male, age 61: 98)*

The focus on the physical rather than listening to the patient's concerns clearly had a detrimental effect on patients' relationships with the nurses. This extract illustrated this when a patient describes being ignored by nurses when she was obviously distressed:



*And at first I wasn't. I was sitting over here crying and people just used to walk past me and ignore it. I don't think they could, you know. It was maybe too difficult for them to just stop for minute and say are you ok...*

*(Patient 21, female, age 28: 62)*

Patients understood that the ward is a busy place but emphasised that they only called for help when it was important. This lack of attention when asking for help, particularly when it came to personal hygiene or intimate care, was significant to patients:

*Eh that ward for the arteries I found when I was in there and again I am not seeking any person attention care I felt that when you wanted something quickly they wouldn't come just right away that's yes [incomprehensible] you maybe wouldn't see her so about ¼ of an hour or even more and by that time it was too late you know and I was doing jobs in the bed and it was hurtful to me...*

*(Patient 8, male, age 80: 159)*

Experience of poor nursing care does indicate a great deal about what it is about nursing that patients value. The extracts indicate that patients want to be listened to, to be given credit for the management of their illness, to be treated as an individual, to be treated promptly and to be given non-judgemental care. They want nurses to think about what it is to be in their situation and to be treated accordingly.

Even though patients did indicate that they were sometimes unhappy with aspects of their care, their faith in nursing staff was constant. This contradiction between poor care and positive evaluation of nursing care is examined in Chapter Seven.

Positive experiences of care also emphasised to patients what was important to them:

*Well see I was getting an operation and I was starved all day right like, a minor operation but you have got to be starved and you maybe you've got tae wait about 4 hours after it before you can eat and that maybe can take till about 11 o'clock at night....and eh they come round and say well I am ready for eating but I have nothing to eat, like some toast and jam and a cup a tea? I says that would do fine that would keep me going till the next morning now they go out of their way and dae things like that.*

*(Patient 4, male, age 58: 17)*

Another example illustrated how important it is for nurses to be there for them:

*If, even here sometimes, once everyone's on the machines, sometimes have a few quiet minutes. I've seen them just coming over, say how are you? How's Henry? How's this and all the rest of it. Just take a few minutes and then go away and get on with their work. And it really is nice. I think it's nice.*

*(Patient 17, female, age 72: 66)*

Positive experience of care tended to involve the human skills: simple expressions of concern which allowed the patient to see that the nurse could understand things from their perspective, or spending time with the patient and not doing specific technical tasks.

## **Summary**

This chapter has identified and examined a number of important theoretical elements for this study. That patients talked about their own experience of being a patient when asked about their nursing care is significant. This suggests that patients make sense of nursing care only in relation to what it is like to be a patient, rather than examining nursing as a separate entity that has nothing to do with the way they *feel* about being in hospital. This has some important methodological implications for how nursing care is evaluated.

Patients come into hospital under a variety of circumstances and these circumstances have implications for how patients view being in hospital. In particular patients admitted for a crisis event, when there is great uncertainty and emotions are high, display vulnerability and anxiety. Patients have to learn the rules and 'know the score' about hospital life and what is acceptable to both nurses and other patients. In order to maintain the legitimacy of the nurse's role and live up to the nurses' expectations of the sick role and compliant patients, patients have to learn to manage their relationships with staff and negotiate care accordingly. The 'work' of patients, either implicit or explicit, was acknowledged by patients. Work was significant in maintaining the role of the good patient.

Understanding the role of the nurse was highlighted by patients to be of importance. There was confusion about roles and demarcations between registered nurses and between other professions, particularly unqualified nursing staff, but it was understood that these demarcations would prove difficult in care of patients within the hospital setting. Nurses were considered to be lacking power and influence within the institution. The understanding of what patients valued about nursing was often most apparent at the extremes of care. Particularly good or poor care rather than everyday experiences allowed patients to articulate how they felt about nursing. This again may have implications for further research in this area.

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# CHAPTER 6

## RECOGNISING GOOD NURSING: ACTIONS, ROLES & VALUES

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### **Introduction**

This chapter examines what patients see as important aspects of their encounters with nurses. This developed from the data as a major category. As patients talked about their experiences in hospital it became clear that there are certain roles, values and actions that make some nurses stand out to patients either in a negative or positive way. Chapter Five identified that patients undergo a socialisation process to become a patient, a process that highlights the rules of the ward. It also looked at how social control is used by nurses and patients to ensure that the ward runs smoothly and to maintain the status on roles, although this does not always lead to a good experience for patients. Of particular note is that 'standard' rules are broken for some patients, depending on how compliant they seem and that some nurses are more prepared to negotiate care than others, who give 'care by the book'. This chapter aims to examine these issues further, in light of what patients highlighted in the interviews as their view of the good nurse.

### **Actions: Patient focused and needs led care**

Patients identified a number of actions that indicated that nurses were giving the kind of care that they valued. These actions were those that were needs led and patient focused care. Patients identified a number of ways to judge whether care was needs led and patient focused: if nurses noticed the small things; if they were prepared to 'go that extra mile'; whether the nurse fitted into the ideal type and showed a sense of vocation.

Negative examples were found when patients indicated that there was a focus on physical care rather than care of the person.

Being patient focused is highlighted in the kinds of relationships that patients have with nurses. Perceptions of good or not so good care (as patients did not refer to bad care) were based on relationships with staff. At times these were described as paternalistic with patients talking about being told what they could or could not do, being told off for breaking the rules and not being a good patient. Nurses were also described as being a friend, particularly for patients who were regularly admitted, or merely as technicians who come in to get the work done and no more. A positive or negative view of the relationships that patients had with nurses coloured patients' views of care.

Patients focus on needs that have to be met from the patient's perspective, rather than what tasks the nurses have completed in relation to their care. This involved nurses 'doing what you want them to do' (Patient 3, male, aged 27: 23), rather than focusing on professionally determined needs. This is illustrated in the extract below where this patient indicates a task that is professionally seen as a need:

*Oh we have to take your blood sample and do you mind? You don't mind because you've got to get it done anyway you know.*

*(Patient 10, female, age 78: 60)*

Nursing care is judged on how well nurses are able to meet patient defined needs rather than undertake nursing focused tasks. For more experienced patients the need may well be to have a technical task completed by the nurse as patients become more aware of the need for technical tasks, such as the administration of intravenous medication of Cystic Fibrosis (CF) patients and being put on to dialysis for renal patients. The key feature is that the aspect of care or task has to be identified by the patient as a need:

*I don't know. I think they're just, they're just there when you need them really. It's em, it's not specifically one thing that they would do. It's just that they're there if you need, if you need anything or if you're not feeling so great.*

*(Patient 26, male, age 20: 24)*

The importance of meeting patients' requested needs became more apparent in incidents where patients seemed unhappy about their care. Incidents in which patients did not feel care was as good as they had hoped tended to be because a need was not met quickly enough or not met at all:

*No, you don't. I mean, you certainly can ask and they will generally come up with the answer. But sometimes you know, because they're quite pushed, they'll forget as well. So you probably would have to ask more than once you know. And sometimes you don't really feel like it. You just have to say oh forget it then you know. So I mean that can happen quite a lot.*

*(Patient 19, male, age 40: 12)*

The patient's world is dominated by time: medicine rounds, ward rounds, observations and procedures, and time was a significant feature in the interviews. Many patients were dependent on nurses for basic care tasks and waiting for nurses to carry out a request was a feature of the interview. At times it seemed that the patient's time and the nurse's time worked on different scales. Pediani (1998) illustrates this:

*'For practical purposes, a jiffy is what you say you will be back in when a patients asks for a bed pan or to be assisted in putting in their dentures, and can be anything from five minutes to infinity.'* (Pediani 1998: 693)

Patients did not want to bother the nurses as they considered them to be overworked and had an understanding that there were other patients in the ward, but when patients did request something from nurses they expected that request to be met promptly as the extracts below indicate. The idea the nurses were 'quite pushed' or 'run off their feet' (Patient 15, female, age 62: 10) and they had to meet the needs of other patients in the ward was a caveat to most of these 'complaints'. Edwards *et al* (2004) and Williams *et al* (1998) report that by considering the intent of an action that results in poor care, patients can 'make allowances for poor care, and avoid evaluating it negatively' (Edwards *et al* 2004 :159). This serves a purpose: as patients are relatively dependent on the health care system, they want to maintain good relationships with staff and they want to have a positive view of care (Edwards *et al* (2004). Edwards *et al* (2004) suggest that these re-interpreted evaluations (in light of mitigating circumstances) should not be taken at face value and methods of inquiry should be used that capture the 'negative,

untransformed' (p159) views of patients and can show how patients develop their opinions.

The work of Edwards *et al* (2004) and Williams *et al* (1998) are important to this study. Williams *et al* (1998) study examined whether people who have recently had care from mental health services evaluate those services and if so what the processes were involved in assessment. Fifteen interviews with new referrals to a community mental health team in the Wales, UK were interviewed with a theoretical sampling strategy used to develop further interviews (eight further interview were held) to develop the theoretical elements of the study (Williams *et al* 1998). This study identified that experienced described by users in positive and negative terms don not necessarily equate with their evaluation of services. Edwards *et al* (2004) followed this work, to explore the transferability of Williams *et al* (1998) study, with a similar study set in orthopaedic surgery speciality. A longitudinal design and in-depth interviews were used to gather data with nineteen patients. This study found significant evidence to support the conclusions of Williams *et al* (1998). This seems to be reflected in this study, further supporting the transferability of findings from both studies, and will be examined later in this chapter.

There were occasions where the mitigating circumstances become less important and patients evaluated their care at face value, for example, a nurse taking their time to meet patient needs because there were others in the ward more in need of care seemed to be acceptable, but forgetting an aspect of care was less acceptable to patients:

*... like you ring your bell and they come down oh right right and you ask them for something and they are like ok we will get you it we will get you it and the next thing they are away doing something else and you have got to ask for it again oh I forgot I forgot, well I asked you ken what I mean?*

(Patient 3, male, aged 27: 61)

*Oh when things just don't get done when you want them which is true which is no that important, but when things get forgotten about.*

(Patient 2, male, age 61: 23)



This is particularly the case when an aspect of care is forgotten about or a worry is ignored that either may be detrimental to the physical state of a patient or will cause some emotional stress or embarrassment. In these circumstances patients are prepared to evaluate care negatively:

*I mean especially like me, because I have trouble in dialysing, especially just before I come off my blood pressure shoots down. But nobody's ever bothered to find out why that's happening. You know they just say oh we're going to give you some saline, stop my weight. But they haven't really decided, or checked why it's happening... they don't seem to bother about it... And I asked to see a doctor here and the response I got, I don't know if they were joking with me or what, but all she turned round to me and said. Well we're very busy now and I haven't got time. That's not the response you need. That's not what you need to hear.*

*(Patient 20, female, age 41: 34)*

Another patient described his distress when waiting for an hour that morning for someone to close his curtains so he could use a commode because he could not walk to the toilet at the other end of the ward. So, although there is some understanding of the fact that there are other patients who may be more dependent than themselves and nurses may be busy, this is not acceptable when it is detrimental to their own care. However, the fact that nurses are busy with patients who are 'more in need than me' (Interview 15) makes patients feel that there is:

*...no point in getting up and jumping up and down saying well you said you would do this such and such and it's not been done. It's not going to help me. It's not going to help them you know.*

*(Patient 15, female, age 62: 45)*

So patients not having their needs met in a period of time that is acceptable to them, or indeed not having them met at all, does not mean that patients will complain or evaluate care as a whole badly, even though having needs met is a fundamental concept in the understanding of the patient encounter.

## RECOGNISING PATIENT FOCUSED CARE: CARING FOR THE INDIVIDUAL

The above extracts indicate that being seen as an individual, in the wider context of the needs of other patients in the ward and in the wider context of the hospital, is important. This was highlighted in Chapter 5 when nurses showed their caring skills when dealing with difficult or disruptive patients. Caring for the individual also relates to *care by the book* and *problem patients* categories previously identified.

A major theme of the interviews was how a nurse's technical skills, interpersonal skills and personality characteristics come together to ensure that the patients are treated like individuals. Patients highlighted that all patients were individuals and needed to be treated as such:

*Yeah. I mean I think that is sort of the personal touch if you like, does make you feel, alright, ok. You know I'm part of this here or, but you know they do know what I'm about or something you know. Em, whether it's something simple like em, remembering you know, how's your flat? You've just moved in sort of thing. Or whether it's more to do with your personal care in terms of oh you like to have the fluid off you know gradually or something like that.*

*(Patient 16, male, age 26: 4)*

*They are much about the same but as I say you have got treat the patients differently you cannie eh. Well I might be a cheery patient and they might be a sort of wee crabit well the nurses latch on to that and try and relax people an and treat them with respect as individuals aye.*

*(Patient 4, male, age 58: 137)*

This last patient demonstrated an understanding that nurses cannot treat all patients in the same way and that care has to be tailored to the individual. He also highlights that guidance about how the nurses approach an individual comes from the patient rather than from the nurse. It is this ability in nurses that makes certain nurses stand out from other nurses:

*I don't know just their... their eh just its funny to explain... ken they have got all ways of talking to residents the residents and that makes them feel better for there's one or two are well they are good nurses but but just not got the same...*

*(Patient 5, female, aged 57: 157)*

The importance for patients of being treated like an individual was highlighted when negative cases appeared, when patients recounted experiences when care was not focused on the individual. This next extract illustrates this point and highlights a patient's frustration when he was not treated like an individual. This patient talked about his pain control after he had had a chest drain inserted:

*I have already told I don't know how many times to tell them that the paracetamol don't work and they keep saying well most operations nowadays major operations like paracetamol is the thing that they give you eh. But just didn't find that it was doing anything at all.*

*(Patient 3, male, aged 27: 83)*

'Pain is what the patient says it is' is a well known mantra of nursing practice, but this patient did not feel that the nurses listened to what he was saying about his pain. He was told about the normal pain control for patients and what pain control most patients required, and he was expected to fit into that mould. He did not feel this standardised approach to pain control was working, but the nurses did not listen to his point of view.

It is of particular note that a significant number of the negative cases relating to being cared for as an individual were to be found amongst the patients who were attending hospital for renal dialysis. The effect of the influence of the ward routine and the hospital context was very significant amongst this group. The following extract highlights the view of a number of patients:

*Yeah well I think. The problem was I don't think they really differentiated between patients. You were all the one mass of people. You were all a dialysis patient, you know, dialysis patients.*

*(Patient 19, male, age 40: 20)*

#### NURSES AS INDIVIDUALS

Within the interviews patients also highlighted the importance of seeing the nurses as individuals and having a reciprocal interest in the individual nurses. The extract below highlights a number of important points in that the patient said that he saw nurses as people not as individuals and he could see the stresses of their life on their faces. When patients know the nurses as well as this within the context of a long term relationship

this has implications for the assessment of their practice. The success of the relationship means that the objectivity that may be required for some aspects of formal assessment is lost:

*There's a lot of them [nurses] out there that see us as people. Cause you get close to us ken what I mean. We get close to them know what I mean. If you see. They see the stresses at our life with us coming in here, because it's in our case notes man. Right but, me, I get to know some of them really well and I can see the stresses of their life just on their face man, just by the way they are. If they come in and they snap or if they're like this ken, you can see that something's getting to them. You're like what's wrong with you? And they'll, ah nothing blah blah blah. And you can second guess it ken what I mean. Is it this and that ken, you know what I mean. They're people man. They've got a life. You're in here and you're no go your. Your life's on the outside. Well their life's on the outside tae when they're in here ken what I mean. I mean maybe they walk away at the end of the day but they've still got a life ken what I mean. So when they come in, sometimes they bring it in with them ken what I mean. But they dinnae talk, they'll no. This and that and they'll take it out on you. You just ken they're no their usual self like they ken when we're no our usual self. That's how well you get to know each other ken what I mean.*

*(Patient 25, male, age 21: 42)*

Understanding nurses as individuals extended to patients trying to understand the impact that being a nurse might have on the personal life of a nurse. It is clear that patients thought that this impact was considerable and that conversely nurses' personal lives may have an impact on their work:

*Aye as I say it takes a special girl for tae dae what they dae and the hours they put in 12 hour shifts is a bit much for anybody cos by the time that they get finished their shift at 8 o'clock at night what can they do just go have have a meal, shower and go to bed ... get ready for the next shift you know they have not got much of a private life you know not unless they maybe get 2 days off or something like that but eh apart from that they have a hectic life ken that they are never off their feet during the day a 12 hour shift eh they it is a bit much I think to ask a girl.*

*(Patient 4, male, age 58: 157)*

*They are always ready to listen to you and always cheerful you know you never sort of look at them and sort of think oh she got out of the wrong side of bed this morning or or what her husband said to her [laughs] or anything they are always cheerful.*

*(Patient 7, female, age 82: 25)*

*I think so yes. I mean after all, these girls are put under a lot of strain. I mean they're bound to be. They must go home at time absolutely exhausted. At least I know I would go home exhausted.*

*(Patient 15, female, age 62: 10)*

Patients see nursing work as being both physically and emotionally demanding and both of these aspects may affect the nurse. The fact that nurses may be tired by physically demanding work, juggling different patients' needs and long shifts leads patients to consider that their home life cannot be as satisfying as it would be for someone with a less demanding job. What is interesting is that although patients understand that nurses are individuals and that they have a busy and stressful job there is an expectation that nurses should not bring problems of their home life into work. There is an expectation that whatever may be happening at home or at work they remain professional and put the needs of the patient first. Patients discussed their dissatisfaction with nurses who bring their own problems into work or let their work conditions affect them and suggested that relationships with nurses suffered because of this. This was highlighted in a number of other interviews:

*Well if especially if they want nursing, and I've heard it mentioned as a profession. You know, if they want it to be a profession then you know, they shouldn't be believing you know, how much under pressure they are and they shouldn't be believing how horrible a job it is. They should be able to put that to the backs of their minds and get on with their work. I don't think it. If you're a professional you shouldn't be affected by these sorts of things.*

*(Patient 19, male, age 40: 100)*

*You may have had a bad night the night before. You may have had an argument with your partner ...different reasons. But, all it takes is one off shot and somebody somewhere is going to call a spade a spade.*

*(Patient 14, male, age 52: 101)*

Patients indicated that this division between home and work and managing the institutional and patient priorities at work is difficult but this awareness is accompanied by an assumption that nurses should be able to cope. This is what is often referred to in the professional literature as the emotional labour of nursing (Smith 1992; James 1992). This emotional labour like physical labour is hard work and often comes at a personal cost to nursing staff. Going the extra mile and giving your all is what patients want and patients do see that this affects nursing staff, yet it is still held as an ideal for nurses.

The fact the patients 'connect with different nurses' suggests that the hospital is a reflection of the real world. As with life outside the hospital, some people will get on better with particular individuals. This makes a person more approachable, which in turn enhances the nurse/patient relationship:

*And I think that whether that's bedside manner or whether that's just me connecting with certain nurses where maybe other people you will connect with other nurses better in terms of you know. And I think that's reflected in society I would have thought, that some people get on better with other people. But em, yes certainly if you get on well with a nurse you can, they're more approachable, then you're not afraid or as afraid to ask the stupid questions you know, or what we deem to be stupid in your own head.*

*(Patient 16, male, age 26: 16)*

This emphasises the importance of nurses' personality characteristics for the patient. As the individual relationship with the nurse is what is valued, nurses with whom a patient gets on better, or makes a better connection with will seem like better nurses. This very subjective aspect of the patient/nurse relationship is an important concept when examining patients' views of assessing the competence of nurses.

## GOING THE EXTRA MILE - THE WEE THINGS

How nurses respond to patients shows a level of commitment that was valued by patients. Patients acknowledged care that was more than 'needs led' or asked for as special and were able to pick out individual nurses who made a special effort for them. 'Going the extra mile' (Fosbinder 1994: 1085) meant doing the 'wee' things that patients appreciated. These wee things often signified the nurse's ability to appreciate a patient's



particular needs, either physical or emotional. This idea of being patient focused rather than nurse or institution focused seemed to be important to patients as they discussed incidents of care.

The importance of the wee things is highlighted in these extracts.

*I saw one of them just yesterday cutting the wee man's moustache there and he was fair chuffed you know just wee things. The old man says I am wanting my moustache cut and they say oh right right, it is all the wee things that count.*

*(Patient 2, male, age 61: 157)*

*Well see I was getting an operation and I was starved all day right like, a minor operation but you have got to be starved and you maybe you've got tae wait about 4 hours after it before you can eat and that maybe can take till about 11 o'clock at night....and eh they come round and say well I am ready for eating but I have nothing to eat, like some toast and jam and a cup a tea? I says that would do fine that would keep me going till the next morning now they go out of their way and dae things like that.*

*(Patient 4, male, age 58: 17)*

*Yeah there's a lot. It's only, I say, they're only little things, but to us they're very important I think.*

*(Patient 20, female, age 41: 208)*

It is interesting that the patients call these 'wee things' suggesting in some way that these are not important, when it is clear that these wee things made some of the greatest impact on patients. Taking care of the wee things showed the nurses' ability to see the world from that patients' view and do something for them that significantly improved the quality of the patient's life. These were not highly technical procedures but showed the patients that the nurses were caring for them.

## BEING THERE

One of the most important ways in which nurses showed patients that they were interested in the patient as an individual was by being there, being available to patients when they rang their buzzer or just popping in to ask 'how are things? The actual physical presence rather than the particular skills of nurses was something that was



really important to patients and this was brought up in the interviews on numerous occasions:

*Aye they dinnae just ignore you or eh oh I will see you in the afternoon if I have time ken they just go and if they've no got the time they just get another nurse for to see to me and that you know it's unbelievable aye.*

*(Patient 4, male, age 58: 29)*

*If, even here sometimes, once everyone's on the machines, sometimes have a few quiet minutes. I've seen them just coming over, say how are you? How's Henry? How's this and all the rest of it. Just take a few minutes and then go away and get on with their work. And it really is nice. I think it's nice.*

*(Patient 17, female, age 72: 66)*

The extract below is an example of being there when the need is not directly to do with a patient's own condition. The nurses were there for the patient both physically and emotionally when his girlfriend died. A number of the patients with CF highlighted this type of relationship with the nurses and described nurses as friends because they had known the nurses for so long and depended on them for a lot of support. The extract underlines the above discussion of the wee things and caring for the individual:

*Well when [name] passed away, that's my girlfriend. Ken, even the folk, some of the staff that you didnae get on with, didnae see eye to eye with, even they were. Ken what I mean? Every single one of them pulled the gither. People sat with me until I fell asleep at night. Em, I got written up for Temazepam, so they'd sit with me while I took my tablets and while I fell asleep. If I woke up greetin' and that I just had to push my buzzer and somebody would sit with me and comfort me and ken. Naebody'd leave me on my ane, ken what I mean? So they're quite good that way and they done their best to cheer me up. I mean that picture frame there, [name of nurse] did it, one of the night sisters, well night shift nurses. She come in, brought that in for me and says. Here's that for your photo.*

*(Patient 25, male, age 21: 8)*

The actions of nurses: being there; taking account of the wee things and caring for the individual, were primarily how patients judged nursing care. These were actions though that were not based on technical skill but using human skills and an understanding of what it would be like to be a patient.

## Roles and Values: Vocation as an indicator of being patient focused

The actions of being patient focused and giving care led by the needs of patients highlighted a number of roles and values that patients expect nurses to exhibit. A number of indicators of being patient focused were identified by patients. One of the most important was whether the nurses showed vocation:

*Well they hear so many grievances and they see so many bad things, you know illnesses, diseases and that. So I mean it's not a job that anyone can do. Personally I don't think I could do it myself.*

*(Patient 13, male, age 72: 16)*

*they are very good, they are angels*

*(Patient 6, female, aged 63: 23)*

During the interview patients discussed nurses as being special people, and the suggestion that nursing is not an occupation but a vocation was evident in conversations with patients. The idea that the essential skills for nursing were in the nurses before they became nurses was evident in the data. Nursing that is valued by patients is about people rather than technical skills. The extract below highlights that caring is seen as natural, and the patient relates nursing work to his own experience of feeling sorry for another human being:

*No no no, you've got to, you've got to be dedicated. You've got to, (pause) you've got to care for the person. I mean years ago I used to walk down the street. I would see an old wifey walking up the road and I would see her in a plaster, I would see a big bandage and you would feel oh that must be sore. You feel that. And that to me is feeling sorry for that person. In here they wouldnae dae that. It's just, you're only a number.*

*(Patient 12, male, age 55: 91)*

This idea of professional nursing care being seen as natural is one that has been previously documented (Smith 1992; James 1992; Davis 1995) and the nursing profession itself has highlighted these caring behaviours: 'smiling, holding, talking'

(Smith 1992: 4) as those that make nurses special. These are strong media images that still encapsulate the public image of nurses.

Vocation is a longstanding concept in nursing and is linked with the idea of the ministry or religious order, the idea of a calling (Mackay 1998). This links with patients' views about 'special girls' giving everything to the job and is also supported by the suggestions that nursing is a way of life, that nursing affects your personal life and vice versa. Within the profession there are some tensions about how to reconcile both the professional and the vocational aspects of nursing. There is a suggestion that vocation has been weakened by the marketplace of the NHS where the emphasis is on skill and outcome. Mackay's (1989) research suggests that practising nurses concur with the patients' view that good nursing is about sacrifice and giving your all to the other, giving that bit extra. Mackay (1989) also found that there was a lack of focus on intellectual and practical skill. This idea that the good nurse has lay skills, those of being a good woman (Davies 1995) is longstanding and can be traced back to Florence Nightingale, propagating the idea the nurses are 'born and not made'. Their skills are not taught but are integral to the person. Patients talked about nurses being 'angels' or indicated that they could not do what nurses do as they [i.e. the patients] are not as patient and kind as the nurses. This tension resurfaced during the introduction of Diploma Nursing courses in the early 1990s when there was an outcry that these nurses would be 'too clever to care' and that the entrance and course requirements would put off the perceived traditional nursing intake of 'nice girls'. Along with the ideas of personal qualities, a vocation is associated with notions of obedience and discipline. Although nurses make up most by far the largest section of the NHS workforce, the occupation has been characterised as unquestioning and relatively powerless. This situation has not been significantly altered by the development of the nursing diploma programmes and the growing numbers of nurses with first and higher degrees.

## THE IDEALISED NURSE

As the patient as a type is idealised by the nurse, as seen in chapter 5, the idea of the nurse is also idealised by the patients. Participants made judgements about nurses against an idealised type and the best nurses fulfilled this idea. Patients indicated the personality characteristics that they valued in nurses. These included being kind, caring, patient, cheerful, nice, committed and 'giving their all'. Even physical attractiveness was highlighted, although in a humorous way, by more than one male participant. This suggests the traditional idealised stereotype of the nurse predominates amongst patients and it came as a surprise to some patients that nurses did not have a personality that met these idealised criteria:

*Well they have got a nice way of putting a thing over and they seem to understand you where maybe there is another nurse who just well I wouldn't like to say they don't like your face but they don't have the same response as others.*

*(Patient 8, male, age 80: 16)*

This last extract also indicates that there could be some element of difficulty in the patient/nurse relationship and that at times it is just impossible to get on with people. This leads some patients to consider that one nurse is better than another, which is often down to how well patients and nurses get on at an interpersonal level. If this is the case then there may have to be a recognition that not all nurses will be seen as good or special by all patients, as it is not possible for everyone to get on to the same degree. These patients indicate that if you get on with a nurse and if they make the effort to understand you, your view of them as a nurse is different. This suggests that being a good nurse is akin to being a nice, likeable, special person:

*I don't know I don't know she just seems to be mair caring but I mean they are all good they are all good ken for caring but she sort of sticks out a mile she has sort of got the kinder tender care.*

*(Patient 5, female, aged 57: 125)*

This extract indicates that some nurses do 'stick out' as being more caring. Patients could make judgments about nurses on the basis of the caring attributes that they

displayed. This is highlighted by the next extract from a patient who actively made choices about who would care for him by waiting for the ‘right’ nurse to come along:

*... if mair nurses had mair compassion then you wouldnae have to wait in picking the right nurse to help you. You say oh you'll dae. Come on hen.*

*(Patient 12, male, age 55: 193)*

The patients in this study saw the personal skills and qualities as important in their judgement of the quality of nursing care. A number of studies of patients' views of care highlight that patients rate these interactional and interpersonal skills more highly than technical skills (Attree 2001; Fosbinder 1994; Milburn *et al* 1995; Thorne 1988), although one notable study conversely reports that patients value the technical aspects of care more highly (Von Essen *et al* 1994). The next chapter will indicate that both of these assumptions are in fact correct. Patients see technical skill as the foundation of nursing practice but this domain of competence is assumed to be under the control of professionals, so patients rarely talk about it as a priority for them, deferring to professional judgement in assessment of skills.

If technical competence was all patients wanted then any nurse would do for any aspect of care but, as the extract above suggests, this is not the case. Lack of vocation does not affect how patients perceived the nurses' technical competence, but it does affect whether the patient sees care as being patient focused. Although technical competence is necessary, being patient focused is a more important concept to patients:

*It's no that they're no competent. It's just that they don't. It's a job. They're not dedicated.*

*(Patient 12, male, age 55: 85)*

*I think, I think they are competent, but I think that you know, it's like a conveyer belt. They do it all day, every day. And putting people on, take people off, wait a couple of hours in between...*

*(Patient 20, female, age 41: 44)*

This view of competence being separated into attributes and tasks reflects the professional debate on how competence can be defined and assessed. This division of

competence into these two elements is an essential theoretical component of this study and will be discussed in the next chapter.

#### ORGANISATIONAL OR SYSTEM EFFECT ON PATIENT CARE – BEING ON A CONVEYER BELT

*You're almost consumed into the machine straight away you know.*

*(Patient 16....)*

The idea of being on 'a conveyer belt', or as another patient referred to it 'being at the milking parlour', further highlights the values that were important to patients; that care of the patient should come before institutional concerns. Nursing care in the dialysis unit was seen as highly routinised. The nurses were under time pressure to get the patients connected to the dialysis machines quickly in order for patients to have enough time to dialyse before the next set of patients were due to come in or the unit shut for the night. The nursing care revolved round a set procedure for dialysis, although there was individual variation in calculations needed for the procedure.

Patients are acutely aware of the way that care is organised and the effect that this may have on their experience of care. The nurse must care for the individual within an organisational system and structure and this creates a tension in the care given. The nurses must be able both to work with the patient as a unique individual and work in the system. James (1992) highlights from her study of nursing care in hospices that nurses did want to give individualised care and not mould patients into the routine of the organisation, but there were times, for example during busy periods, when the routines of the ward came before the patient. Although in this setting the ideal is that individualised care comes first, the reality is that this is not always possible. Even when it is a priority of staff to give good individualised nursing care, organisational priorities and routines come first.

Patients identified that efficiency and good ward organisation were important but only as long as this met the patient's needs and not primarily (or only) the organisation's needs:



*And they're, oh, they work as a team and you can see. They go round the desks and then each one's allocated their certain things and they maybe go away and dae it.*

*(Patient 10, female, age 78: 90)*

*They are very thorough they get themselves, down in the other ward they get themselves very organised and they are here too. I noticed they were they would organise themselves every day with a list of patients to tend to and I noticed a list watching them cos for the most needed ones you know they perhaps leave me till the afternoon to do the dressing knowing that it wasn't too bad you know and that sort of thing and I noticed that was very good.*

*(Patient 7, female, age 82: 8)*

This ambiguous role nurses have and the tension between the organisation and nursing the person is explored by Ryan (1997). The nurse must meet the objectives of the organisation as well as being accountable to the patient who has delegated responsibility to the organisation whilst being unable to care for themselves, or be cared for at home. There is a danger that by understanding the organisational objectives and the way the system functions, nurses will ignore the limitations that they place on care and not acknowledge them in their care.

Nurses have traditionally identified themselves with the organisation, the hospital or the unit in which they work, rather than with the patients (Ryan 1997). The organisation, particularly the hospital, has a strong influence over those who work there and it is this world, rather than the patient's world, that the nurse is socialised into. Organisational and political concerns about litigation, equity, quality and efficiency have taken precedence over professional aspirations to be autonomous and flexible in practice with individuals, leaving nurses uncertain about which master to serve. Attempts have been made to redress the balance. For example, the book by Walsh and Ford 'Nursing Rituals' was written in order to develop skills in being:

*'...accountable to the patients, rather than to institutions and establishments...'* (Walsh and Ford 1989: ix)

Walsh and Ford describe nursing practice as being ritualistic and bound to the needs of the organisation, for example the timings of medicine rounds, bathing and switching the



lights off at night, without consideration of an individual's personal preferences and needs. Since this book was written there has been an increasing emphasis on formal procedure and 'ritual'. There has been a significant increase in influence on nurses from external forces, for example, the increasing influence of government initiatives such as The Scottish Intercollegiate Guidelines Network (SIGN) in Scotland and The National Institute for Clinical Excellence (NICE) in England and Wales.

These agencies originated in the early 1990s and their purpose is to develop clinical guidelines based on the current best evidence in order to improve the quality of care for patients in the NHS and to reduce variation in practice and outcome for patients. The guidelines are on varied topics of care from asthma management to cancer care. Although local guidelines have been available to practitioners for some time, these are often not based on a systematic review of the scientific literature, but on expert opinion. These new 'evidence based' guidelines are developed to reduce the amount of bias and regional variation in opinion, particularly where care is known not to be delivered uniformly throughout the country. Devolution in the UK has made these agencies separate in Scotland and England, but plans are underway to develop guidelines that will be utilised nationally. The Royal College of Nursing's Quality Improvement programme has developed nursing guidelines for use across the UK (Royal College of Nursing 2004a).

The Institute of Medicine in the USA defines guidelines and within this definition stresses the importance of service users, which indicates that guidelines can be used by them to make decisions about care. Most guidelines are freely available on the internet and from the agencies:

'...systematically developed statements to assist practitioner and patient decisions...' (Field and Lohr 1992 p8)

It is, however, unclear what impact guidelines have had on patient decision-making about care and treatment. The guidelines may in fact restrict choice for patients and for practitioners by being seen as the 'right' way to care and, in an increasingly litigious society in the UK, practitioners may be reluctant to practise outwith recommended

guidelines. The use of guidelines may overpower creativity and individuality in the care of patients, although as the name suggests they have been developed to 'guide' practice. Guidelines are only as good as those practitioners who use them and, if they are implemented as the 'gold standard' of care, it may be difficult for nurses to be able to see beyond them. The extract below suggests that this patient felt that he was the least important and influential person in the hospital:

*I mean the whole idea behind nursing situation is you would go through your training, get your qualifications. In theory then you can do the job, which is correct. But then you're also learning at the same time about how, how the jobs interrelate with everything else. I mean not only have you got. Well I mean we were talking about nursing patients. But I mean you're talking about nursing in the relationships, talking about medical nursing in our relationships, professional people within the specialist groups which are found in hospital that you've to work with, administrators and so on. I mean all these people would have inputs. Who's got the ultimate say? Certainly not the patients.*

*(Patient 14, male, age 52: 116)*

Within hospitals there is also an increased emphasis on local policies and procedures with standardised care pathways through the hospital and the community in place, many of which have had a less than rigorous evaluation. There is pressure to fit patients and nursing care into standardised units that can be counted and evaluated numerically.

Not only do written policies and procedures ensure the organisational dominance of care, but the development of professional social systems and rituals puts the professional agenda first. Menzies (1960) describes defences against anxiety, such as depersonalisation of patients and detachment from patients, as examples of the needs of the profession coming before the needs of patients. The nurse has to manage the individual patient in the ward, the hospital and the wider political structure.

It was apparent in the data that patients did see the tension between what they needed for themselves and the compromise within the organisation, as can be seen in the extracts below:

*I mean I expect that now but some people, they wait for four hours so it would be nice if they knew that this was going to be four hours 'I'll go and read a book' and you say, are you going out today? dressed ready, you will get your letter and your pharmacy will come up shortly and it is four hours it is a bit stressful for some people.*

*(Patient 2, male, age 61: 109)*

*The system here is on such a tight schedule from say 8 o'clock in the morning, through to well when we start you know, probably as late as half past 7 you know. It is. There's no time for anything else I wouldn't have thought. You know the nursing staff do have time to put some feedback to the patients, you know when the rush of getting people off and getting people on. But quite often they don't do that you know.*

*(Patient 19, male, age 40: 30)*

The first extract indicates that it is the need of the wider institution such as pharmacy and portering services that have to come first in order for the institution to work as a whole; the non-urgent needs of one person cannot outweigh the way the system works and there will be delays in services in order for institutional priorities to be met. The second extract was from a patient who was discussing her frustration with the nurses for seeming to withdraw contact when her physical state was improving. The needs of the organisation and the patients who were more physically dependent, needing more time from nursing staff, outweighed this patient's needs for social and psychological support. This patient did express that she understood the nurses are busy with other patients, but saw this as affecting her own care and therefore as undesirable to her.

Nursing in the hospital setting does require a shared set of understanding and values. On a ward of up to thirty patients it would be extremely difficult to meet the needs of all patients simultaneously. Nursing patients then is more than looking at them at an individual level. The environment, the needs of other patients and the organisation need to be taken into account when planning and undertaking care. The ward environment needs to be managed on behalf of the patient and the rights and responsibilities of the nurse allows them to take on this role, but the patient must give the authority to the nursing staff to do this.

It is the fact that the nurse can use discretion in (his or) her authority over patients and the ward that makes the nurse professional, not powers assigned by the organisation:

It is not my employer that makes me professional but my client.

(Ryan 1997:121)

The question that may be asked is: 'does the organisational perspective that staff hold prevent them from giving individualised care?' Good nurses escape the duality. Patients are cared for as whole persons in well-run ward environments and it may be more helpful to see this tension as two ends of a spectrum rather than two different worlds, since these tensions can be resolved within this view.

## TRUST

An important theoretical category that developed from that data was that of trust. Patients give the nurse the authority to care for them through trust and this sanctions the caring role for nurses. Patients did not talk much about the technical competence of the nurse, even though they were prompted to do so during the interview and some were experienced with managing their own illness at home, or were experienced patients in hospital. When analysing the data it appeared that much of this apparent lack of concern for technical ability was due to the trust that patients placed in the nurses who were caring for them and in the system itself. The extracts from interviews below are indicative of patients' views on this subject. Patients have no option but to trust that nurses know what they are doing, because patients are in a vulnerable position:

*I just trust them anyway, because they should know what they are doing anyway, they are in the hospital to do it. I just trust them anyway obviously, they will have been through college to be here so they should know something, obviously to see what is wrong with you and that...*

(Patient 3, male, aged 27: 146)

*You've got to trust it because you're here and they're here to look after you.*

(Patient 12, male, age 55: 49)

*But I think at the end of the day, when you're attached to a machine, blood's flying out your system, you got to be a degree of trust there. There has to be. And you know, you've got to trust a) the nurses know what they're doing and b) you know there's maybe appropriate training in place for certain things, I don't know, but I think that em, there's probably no way to tell I wouldn't have thought.*

*(Patient 16, male, age 26: 20)*

These examples are of patients who spoke explicitly of trust but the theme ran through all interviews. The notion of trust was implicit in talking about nurses and health care; for example, patients talked about feeling safe and feeling that they were in good hands. Patients trust nurses; they trust that they are technically competent as they have been through a course of instruction and that they would not have been employed if they were not competent.

Patients trust both the individual's ability and the system that allows nurses to practise, despite well-publicised cases of medical and nursing negligence. Patients have 'faith in the system'. Trust is a complex phenomenon and, as health care professionals, nurses expect that patients will trust both them and the organisation within which they work. Lupton (1996) examines trust and the medical encounter and sees trust as a way of managing uncertainty, uncertainty and risk being integral parts of medical and nursing care. Trust is developed from openness which is developed through communication. It was seen as important when patients were talking about good or bad doctors, the notion of a good doctor being strongly based on trust (Lupton 1996).

Whether the public trusts the public services has been called into question in recent years and the 2002 British Broadcasting Corporation (BBC) Reith lectures (O' Neill 2002) reflect interest in issues of trust and the public. Loss of trust, O' Neill contends, is a 'cliché of our times' (O' Neill 2002: 9). It has been suggested that there has been an increase in distrust of the health services in recent years, resulting from media interest in medical scandals such as the Harold Shipman case, the removal of organs from children at Alder Hey Hospital and the Bristol enquiry into paediatric cardiac surgery and also more general concerns about how the NHS is managed and financed. This is coupled with wider societal changes reflecting the disintegration of communities and changing

views of public institutions and the authority they have over our lives (Calnan and Sanford 2004). However, it may also be related to changes in the way that care has been managed (Ahern and Hendryx 2003), for example prioritising certain procedures to shorten waiting lists and to improve hospital standing on league tables or rationing of certain treatments due to tighter financial constraints (O'Neill 2002; Checkland *et al* 2004).

Attempts have been made worldwide to measure the levels of public trust in the health service, although the focus of these studies has been on medical care (Straten *et al* 2002 (Holland); Calnan and Sanford 2004 (UK); Mechanic 1996 USA)). Straten *et al* (2002) in their development of an instrument used to measure trust found that trust was a multidimensional concept taking in macro (e.g. accessibility), meso (e.g. relationships between providers) and micro (e.g. interpersonal relationships with individual health care providers) levels.

Calnan and Sanford (2004) report the results of a national (UK) cross sectional survey of public trust in health care. Although the instrument had not been tested for validity and reliability in the UK, it produced some interesting findings in the Netherlands where it was developed. Despite recent public scandals, public confidence and trust in medical practitioners remains high in contrast to trust in health service managers. The top five strongest statements used to determine levels of trust were those that focused on patient centred care such as 'patients are taken seriously' and 'patients get enough attention'. The highest levels of distrust were of the wider issues such as service organisation, waiting times and the implications of cost cutting (Calnan and Sanford 2004). The authors suggest that if dimensions of trust are at their most visible at the micro level, such as being patient centred and professional competence, then trust is closely linked with user views of quality of care. Thus, if trust in health care is to continue to remain relatively high this is where enhancement of service should occur. Dibben and Davies (2004) acknowledge that although personal experience of interpersonal relationships enhances trust in the wider service:



‘excellent interpersonal skill and the development of high levels of ‘private trust’ may serve to shield the incompetent (Dr Shipman of course, was well regarded by many of his patients)’ (Dibben and Davies 2004: 89).

This reinforces the point made by Halldorsdottir and Hamrin (1997) that:

‘from the patient’s perspective, it [professional caring] always includes competence...caring without competence was in most cases meaningless for them as patients’ (Halldorsdottir and Hamrin 1997: 122).

A reduction in trust in health service can have serious implications. Patients may be more likely to ask for a second opinion; they may seek care from alternative practitioners and they may develop an increasing interest in finding the ‘best’ services. Furthermore, a reduction in trust may have an impact on concordance with treatment and care and on satisfaction with care (Gray 1997).

What surveys fail to acknowledge is that we all have to trust to live our everyday lives, so even though there may be a suggestion that we question our trust in the health service, we still use it. The use of complementary health care has increased dramatically in the UK, which may suggest a changing view of the health service, but it still tends to be used alongside traditional medicine. It may be, however, that we have to rely on institutions because in the health services we actually have very little choice in where, and by whom, we are treated.

This is in contrast to the idea of the patient as the consumer of health care. It is clear that patients are better informed than they used to be about their care and treatment with access to resources from user groups and particularly the World Wide Web. Information is abundant, but it is often incorrect and it is difficult for patients to test the information that they have, or see it in a wider context, so they have to rely on health care staff for this. The issue of MMR vaccinations is a contemporary case in point where the scientific evidence should make the decision to vaccinate uncomplicated. Contradictory evidence, personal accounts of side effects and a media fuelled debate has blurred the lines and, therefore, no amount of scientific evidence can make the choice easy for an individual, or on behalf of another individual. It may not be in patients’ interests to question trust at such a time of crisis as being admitted to hospital. Trust is needed because there are no



guarantees of outcome, all medical treatment having some risk of non-therapeutic side effects.

The public are aware that scientific and medical knowledge is open to dispute but there is a feeling that without faith in medicine there is little left, so patients need to trust. Confronting uncertainty with reassurance and hope is a powerful therapeutic tool in the hands of nurses; trust in the health service may be the only thing that makes uncertainty about the future bearable:

Even though people acknowledge the uncertainties around medical treatment and the possibility of negligence on the part of doctors, many are reluctant to relinquish their faith or trust in medicine.

(Lupton 1996: 162).

It is easy to make the assumption that patients should be able make the same decisions about medical care as they do about other services such as going out for dinner. Consumerist approaches to health care assume that patients can approach the medical or nursing encounter with some certainties, but the vulnerability of patients and their dependence on nurses for physical care and emotional support does not make this a clear cut issue.

The health care professions take steps to enforce standards of care with the work of the professional regulatory bodies. A great deal of effort goes into ensuring trustworthy performance. We hear frequently about 'a crisis of trust' and the new consumerism of the NHS is supposedly partly responsible for this (Lupton 1996). So do patients have less trust, or is it that we have a culture of suspicion, fuelled by managerialism, accountability, transparency, new regulations, legislation and protocols? Consumerist discourses that emphasise individuality, autonomy and distrust may generate further uncertainty. The extract below supports this view that perceived lack of trust may be in the management of the health service and not in care itself (Calnan and Sanford 2004):

*Yeah, yeah. I think that's em. I don't think it's misplaced trust either. I mean I think that em, whether they're not trusting the health service. I certainly don't agree with that, but I think that probably that comes more from the. I don't think the higher level, more strategic side of it in terms of shutting hospitals, in terms of shutting wards, in terms of closing you know, basically rationalisation I suppose. And I think that eh, that's probably where the mistrust comes from. It's mistrust of where it's going I would have, personally myself. Cause I wouldn't you know, mistrust certain individuals cause as I say, you know. You see it every day you know, people are doing sort of long shifts and ... and I think that you do place your trust in them for that reason.*

*(Patient 16, male, age 26: 86)*

One patient mentioned the Shipman case (when a doctor in England was convicted of murdering 17 of his patients), yet even when cases like this are in the press it is difficult to undermine trust in care:

*I think I. Well I think with what we've all sort of grown up with a trust in health professionals. You know, maybe we don't want to undermine that within ourselves possibly. Do you remember the Shipman case where he murdered lots and lots of patients? But there was just an inbuilt trust in everyone, from the coroner to the undertakers to the police officers who just couldn't quite grasp the fact that the doctor was murdering people. And I think we all have that. When we step out, especially in an area where we're not professionals and we don't know, we sometimes tend to assume that the person who's done it before is doing it correctly. And I think that's maybe why we tend not to say anything at the time.*

*(Patient 19, male, age 40: 48)*

Professionals have had to work with changing standards of practice and are required to record and report these. This new accountability is distorting practice and means that there is less time to spend with patients and more time is spent in preparing evidence that they may need to protect themselves, with professions beginning to work towards defensive care. There is a focus on performance and outcome indicators that make it easier to measure and develop care, rather than the process of delivering care and the experience of the patient.

Much of what patients said about nursing staff suggested that they trusted them. Patients in this study rarely questioned the technical competence of nurses, even when not appearing satisfied with care or expressing doubt about their treatment. There is a

gamble when trusting another person and much depends on the relationship that a patient has developed with the nursing staff. Patients talked about having a good relationship with the nurses which facilitated communication, understanding and trust:

*Well I wouldn't. I don't feel scared they'll let me go hypo or anything or anything'll go wrong with my medication or. No I've not got any doubts that I'm being taken care of.*

*(Patient 11, female, age 35: 54)*

*Eh definitely. Especially the nurse, I think cause the nurses frae here are like, they're no strangers cause we know them that well and I would trust any one of them to dae any procedure. Know what I mean? So, maybe no happy with ... have to get a catheter or something like that or if you get anything like that. I mean obviously you're no gonna be happy, but I would still trust them and I would prefer the staff from this ward. But I think if it was in another ward that I'm no too sure then, I didnae really have a clue. But this ward definitely.*

*(Patient 22, male, age 20: 90)*

Trust is needed on both sides of the relationship in health care as the nurses must trust the patient to give accurate information and comply with treatment, as has been seen in earlier chapters. This is particularly important where patients are taking responsibility over some aspects of their care, creating grey areas in accountability as was discussed in Chapter 5:

*I mean like, like they'll come in. They trust with us with a, like they'll leave like the medicine they can like put down. They can leave that lying about as in with most patients that are like, when they go into see them in the bays, it'll be like. Right well there's your medicine take it, and they'll probably watch them take it. But because they know us that well they can trust and you know. So it's pretty good that way.*

*(Patient 22, male, age 20: 6)*

This relationship is essentially an unequal one with patients often having to open up to nurses and discuss difficult personal information without the nurse having to reciprocate. In fact one of the reported defences against anxiety for nurses dealing with the problems of others is to withdraw from personal interactions with patients (Menzies 1960). There is a tension between autonomy and dependency in the nurse/patient relationship which makes taking risks and trusting others complex, and depending on the uncertainty of the

outcome of a situation, it may be more difficult to be consistent in taking on these roles. This fluctuation of roles between compliance and distrust requires the constant renegotiation of the relationship.

Trusting nurses to the extent that patients do, sometimes blindly and sometimes with caution, further complicates the idea of patients assessing competence:

*LC        Are there any other aspects of nursing that you think patients can judge about nurses?*

*P        I'm not sure. I suppose you just have to put your trust in their hands don't you?*

*(Patient 21, female, age 28: 119)*

As the above extract indicates, patients seemed to find trusting nurses to undertake care to the appropriate standard somehow incompatible with assessing their competence. Trust as a strategy means that you do not have to think about whether the nurses are competent and this is a protective strategy for patients to take some of the fear away from uncertain situations.

Transparency has been seen as a way of improving trust in the public sector and this can be clearly seen in the health service. However, it has been questioned whether transparency has in fact led to greater trust (O'Neill 2002; Smith 2004; Checkland *et al* 2004). Smith (2004) argues that transparency has equated to a flood of information when what is needed is 'accurate, understandable, interpretable, unspun, checkable information' and claims this is why the England's star system for ranking NHS Trusts has been discredited. We now have more information about the health service, but if trust is an active process rather than a passive one, patients need to be able to have a dialogue with information in order that they can understand and interpret it.

## DEPENDENCY

Another category that sanctioned nurses to care and make decisions for patients was dependency. In contrast to 'taking responsibility' over some specific aspects of care, usually to take the burden off nursing staff rather than because patients felt that taking

responsibility might be useful for them when they were discharged, as discussed in Chapter 5, being dependent on the nurses was a strategy used by patients to ease the burden of their illness. Being dependent puts patients in a difficult role in terms of assessing competence, even when they have relinquished independence willingly. Making others responsible for their care and decision making and relying on the professional expertise of the nurse rather than their own expertise reinforces the balance of power in favour of the nurses. As with trust, when you are dependent on someone it makes it very hard to evaluate what they are doing because you have chosen to put your care in their hands. Some patients for example, the acutely ill, have to be dependent on others because they can't take responsibility for their care since they are physically unable to or they lack the expertise. This patient talked about the nurses giving him his insulin, which he saw as part of their job as he was feeling unwell:

*Well it didn't bother me cause that's part of their job isn't it you know. And it could be you see, I might be feeling that way off and forget to take it.*

*(Patient 10, female, age 78: 40)*

Renal patients are also dependent during dialysis as, although they could take responsibility over some of the technical aspects of getting on to the machine, they are dependent on the nurses when they are being dialysed. Firstly, this is for the care they need during dialysis as they are not able to take responsibility for this, and secondly, because they are physically limited when on dialysis so all their other needs such as eating and drinking have to be met by nurses; for example they can't go and get a glass of water as they are attached to the machine.

#### WILLING DEPENDENCY

Patients in the study did indicate that they moved from being dependent to being independent, although for some patients the move was at the instigation of the nurses:

*But then they were giving me my insulin, but they decided they would give me insulin to treat myself and then I do it myself.*

*(Patient 10, female, age 78: 8)*

*Yes. I mean, well when I first came in they were doing it for me and then they said. You know, do you have your own machine? [dialysis machine] I said yes I have. Would you like to do your own?*

*(Patient 15, female, age 62: 52)*

For other patients they chose themselves, sometimes on a daily basis, whether they would be independent or dependent in care.

*I normally do them in the afternoon. But then, first thing in the morning they'll do them for you which is something I wouldn't get when I was at home.*

*(Patient 24, male, age 23: 44)*

This choice of being dependent or independent was particularly noticeable amongst the patients with Cystic Fibrosis (CF). These patients negotiated with nurses about which aspects of their care they took on and at what times; they indicated that 'sometimes you want the responsibility and other times you don't' (patient 24):

*Em, it's, sometimes it's quite good. It saves me having to make up my IVs and stuff like that. But other times, like if they want to give the IVs, then sometimes I'd rather do it myself because like I do at my own pace and just easier sometimes.*

*(Patient 23, female, age 23: 16)*

Leaving it up to the patients to decide what level of assistance they wanted seemed to be acceptable to the nurses. The patients with CF particularly looked at the hospital admission as a way of easing the burden of their illness and the patients appreciated the nurses being patient focused.

This discovery led to the development of the category 'willing dependence', which included incidents where patients willingly became dependent on the nurses for an aspect of care that they could carry out for themselves. This was different to instances in which patients talked of being dependent because of their condition or because of the nature of the care and treatment they were getting. For the most part nurses did find this acceptable, but there were times where this willing dependence went too far, leading to tension with the nurses:



*Aye that's what it is. That's what's good about this ward cause it's like. The nurses in this ward it's like you can compromise with them you know. So, this, that's what's good about them. I actually feel quite bad. There's this nurse yesterday, I was moaning at her for ages to go down to the canteen to get me chips and cheese and aw the moaning I done for it. My pal [name] was saying to me, oh you want to go down to McDonalds? I just said och aye fine. And there was me all the way to McDonalds with my pal and ... the poor nurse is away down to the canteen and coming back up... chips and cheese here. And she was raging. She wasnae happy about it at all. So I mean we just take them for granted and that I mean like. Aw well a nurse'll go down and get us chips and cheese and at the same time as me forgetting all about that I mean.*

*(Patient 22, male, age 20: 38)*

Patients who had longstanding illness when they came into hospital used the admission to get some relief from caring for themselves. Some patients felt that the nurses taking over care saved them doing it or they used the help nurses could give to give care in a different way that would be beneficial to their long term care:

*Well I mean I come in here and I won't say I look on it as a holiday, but with a little bit of effort on both sides I will you know, start injecting again as soon as I go home. It's as simple as that. End of story. But it's nice to be able to inject somewhere else other than my legs, continuously, 24/7. So, on that score I like, it's nice coming into hospital cause I can, the nurses in theory, can inject into my arms and other sites, which I'm quite happy to give my legs a rest, which is an advantage...For the most part the nurses are quite alright in helping me. Obviously if I suddenly decide tomorrow that I want to start injecting myself I'm sure that they would let me.*

*(Patient 14, male, age 52: 7)*

Negotiating dependence was another factor in letting patients see that their care was patient focused. Nurses who were able to negotiate on a daily basis with patients about their care were valued and seen as flexible rather than caring for the patient 'by the book' (patient 22), as discussed in Chapter 5.

## **Summary**

This chapter has illustrated how patients recognise good nursing, which is patient focused, needs led and characterised by a good relationship with nurses (who are seen as people) who are flexible when patients want to negotiate dependence and independence.



Patients' views of nursing care were not 'rose tinted' but incorporated the competing demands of other patients and the institution. Patients wanted care to be fair and equitable, although some aspects of care were idealised, with the belief that all nurses should share the same roles and values, have a sense of vocation or have a range of personality characteristics.

Patients described being in a position of dependency on nurses. However, patients who place themselves in a position of willing dependency were still in a position of control. A proportion of patients were voluntarily handing over aspects of their care to nurses and this resulted in some benefit to the patients. In some circumstances nurses were able to negotiate this control with patients but in other circumstances exercising this control was a challenge to nurses.

Trust as a category is theoretically important as it is through trust that it is possible to see that on an individual level, rather than an institutional or system level, patients upheld the role of nurses as experts and decision makers, irrespective of the care they received and often making excuses for care that is not satisfactory. This trust means that for the most part patients did not have to evaluate care because they trusted that everything would be all right. Trust is a barrier to assessment of care as patients employed it to protect themselves against the uncertainties of health care; it would be too difficult a prospect to consider that a nurse was not capable of doing his or her job.

Patients clearly made judgements about 'good nursing' based on these interpersonal or 'human skills' skills and waited for the 'right' nurse to come along to give care, so they did make choices about who would care for them. Patients expressed disappointment that not all nurses have these skills. The implications of patients judging nursing care by these human skills for patients' assessment of competence will be examined in the next chapter

The categories in this chapter allude to the fact that patients prioritised issues relating to the interpersonal aspects of their relationship with nurses. This is a phenomenon that has been noted in other research studies (Attree 2001) but an explanation of why this is the case has not been fully explored. There is an assumption that patients consider these the

most important aspect of care, however, the next chapter will contend that the technical skills of nurses are of crucial importance to patients, but that they are assumed and considered to be within the expertise of nurses, not of patients.

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# CHAPTER 7

## REFLECTING ON PROFESSIONAL COMPETENCE: DOES THE NURSE KNOW BEST?

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### **Introduction**

This chapter will explore patients' views of nursing competence. During interviews with patients there was discussion of the competence of nurses either explicitly or implicitly. It was during the stories patients told, and sometimes re-told more than once during the interview, that it was possible to see what constituted the competent nurse. During our discussions about competence and the assessment of competence it was possible to discover the complexities of how patients judge competence, whether patients challenge poor care, in what circumstances this is possible or acceptable and barriers to assessment of competence. A complex and interrelated set of concepts emerged that highlight the complexities of patients assessing nurses' competence. The issues highlighted by patients reflect debates in the literature about competence assessment: what competence is; how objective and subjective aspects can be measured; the importance of transferable skills, developing competence and the significance of making mistakes.

In this chapter, the theoretical importance of themes identified in the previous chapters such as the effect of being inexperienced in hospital care, trust, dependency and the roles and values of patients will be highlighted in relation to competence assessment.

## Learning about competence by experience in the hospital environment

Linking with the category in Chapter Five, *knowing the score/becoming a patient*, patients felt that some knowledge is needed of nursing before being able to make judgements about competence. Patients explained that it is very hard to judge something that you are only experiencing for the first time:

*You would need to be in a couple of times ken, cos I ken people who have been in for the first time in 20 years or something and they are moaning and groaning about this that and the next thing just because the werenae getting one to one nursing and things like and the nurses are hopeless and this that and the next thing that I didnae believe because cos they werenae giving the nurses a chance and they have more than one to look after eh.*

*(Patient 1, female, age 57: 375)*

*P Oh I think so, unless of course, if you've no been in and out of hospital you haven't a clue you know.*

*LC Right. So you think you have to be in a few times to be able [to judge competence]?*

*P But if you've in and oot like I am, you can tell right away. You can practically tell right away just.*

*LC Right. How would you tell right away?*

*P Just the way that their manner and how they go about things and their confidence in what they're doing.*

*(Patient 10, female, age 78: 116)*

*you know, I can go back to when I was 21 years old and I probably never paid any attention whatsoever. But I think it's just basically experience within the hospital environment, gives you that ability to be able to judge competence or not.*

*(Patient 19, male, age 40: 104)*

The important aspect here is that patients talked about being more experienced at being in hospital, not more knowledgeable about their condition or technical aspects of care, (although this may happen at the same time). It is the experience of being in hospital that makes you more able to judge care. Going through multiple admissions, becoming a patient, getting to know the context of the ward, the roles and values of patients and

nurses and becoming relaxed in the environment makes you more able to judge the competence of nurses:

*Aye the first time you have been in hospital everything is strange you are trying to pick up wee bits an pieces and all that and you just do what you are told you know and but the second time you are completely relaxed ...*

*(Patient 4, male, age 58: 202)*

During the interviews patients were asked to talk about the competent nurse and what that meant to them as patients. Responses to this were very similar amongst patients as can be seen below. Statements from patients tended to be quite generalised: 'total care with your patient' (Patient 4) or 'somebody that knows what they're doing' (Patient 10). Patients did not come up with a straightforward list of skills or attributes that constituted competence:

*Well I think I have mentioned again the compassion and organising ability things they have to organise on the spur of the moment it is amazing eh em just caring sharing even the touch of a hand on a hand you know things like that...*

*(Patient 2, male, age 61: 342)*

*Well jolly and happy and relaxed and 100% knows exactly what she's daeing and eh... and she's helping oot and it's somebody you can rely on. I wouldn't have to be sitting there saying to myself, oh my god does she have a clue what she's daeing here?*

*(Patient 22, male, age 20: 102)*

Patients talked about attributes or skills that were described as personality characteristics or caring attributes as essential components of competence 'just in her manner' (interview 10).

*Well competent nursing is really gieing everything...your heart to it and being sure everything is all right with the residents they eh well the patients are happy ken and eh be there for them and that is all I can think of...*

*(Patient 5, female, aged 57: 275)*

*...but they've [the nurses] got to understand what they're doing and why they're doing it. It's no good just being a sort of a regimental and doing things without thinking about why you're doing it or what the readings mean, what the readings mean to the patient.*

*(Patient 13, male, age 72: 58)*

For patients there was a focus on the caring aspects of nursing as well as technical aspects. There is extensive interest in examining what important nursing behaviours are for both nurses and patients. This has been researched in a number of ways, using quantitative scales and questionnaires, (White 1972; Keane *et al* 1987; Wildmark-Petersson *et al* 1996) and qualitative, phenomenology and grounded theory studies using in-depth interviews (Halldorsdottir and Hamrin 1997; Haggman-Laitila and

Astedt-Kirki 1994; Von Essen *et al* 1995).

Even though a wide variety of approaches and methods have been utilised over time, this research spans back to the early 1970s (White, 1972). The evidence strongly suggests that whilst patients identify technical skills and nursing knowledge as being important aspects of nursing care, nurses, irrespective of clinical speciality, tend to focus on the psychosocial aspects of nursing (Patistea and Siamanta, 1999).

## **Technical skill as the foundation of competent practice**

When patients were asked to talk specifically about competence they indicated that competence was essentially about technical skill. Being friendly and kind, the human skills, were added extras that did not make care more technically competent but improved how care was perceived by the patient:

*So I don't think so. I don't think if they're more friendly they're less efficient or more efficient if they're. But I think it may be that, you're put maybe more at ease if someone's em, you know. I think it's very hard to pinpoint I think. I wouldn't say that friendly is more efficient or you know, or more standoffish or professional approach is more you know, more proficient, because it's hard to tell... Yeah I would say so. Yeah I would say it [being friendly and nice] would indicate they were beyond competent yeah.*

*(Patient 16, male, age 26: 12)*

*Cause they can be competent in doing what they're doing because they're doing it in the way they've been showed how to do it, but being dedicated is a different thing all the gither.*

*(Patient 12, male, age 55: 105)*

*well, knowing what is actually wrong with the patients and how to treat it, and being able to explain to them what their tablets and everything are for and what their treatment is for without always having to ask the doctor, I think that would class her as competent, and they are alright that way aye.*

*(Patient 1, female, age 57: 97)*

Patients did identify a dividing line between competence as seen as technical skill and competence as seen as the caring attributes or personality characteristics – a divide between professional care and personal care (Fosbinder 1994):

*No. You've got to differentiate right. The professional care from the personal care because they might. Some of the nurses might actually well love us, ken what I mean. If they cried, they'd shed a tear, ken what I mean. But somebody could come in, an old biddy could come in and she could pass away. They might no cry. They think it's sad but they're no losing somebody close to them. If one of us died it's different. Ken what I mean? That's the kind of better care that you get. Emotionally they care for us better, but they dinnae medically care for us better.*

*(Patient 25, male, age 21: 56)*

Technical skill was seen as the foundation of nursing competence and this finding has been identified elsewhere. Zhang *et al* (2001) from a review of the literature that the difference between superior and average job performance is not the measurable skills but the soft skills, such as personal characteristics. Knowledge and technical skills are threshold competencies which are necessary for individuals to meet job requirements, but skill acquisition does not guarantee effective performance. Nurses need personal attributes and characteristics to translate these hard facts, skills and knowledge into effective action. This supports Von Essen's (1995) findings that important nursing behaviours relate to technical competence but this study indicates that patients see other attributes are critical for competence.



This reflects research on student nurses' views of skill acquisition (Horsburgh 2001, Gray M 1997), which suggests that students' initial focus is on technical skill which they feel has to be mastered before they can move on to developing broader nursing skills. Once they are technically competent, students begin to see care in context and become less focused on technical care. This is similar to the way in which patients see technical competence. It has to come first, and once it is there (or patients assume it is) then they can move on to focusing on other aspects of care and the complex integration of all of these abilities in to the broader nursing role. Initial evaluations of Diploma Programmes introduced in 1992 in Scotland focused on the broad level of competencies to be achieved by students. These switched from skills based apprenticeship outcomes to open and more blurred competencies. This lack of focus on psychomotor skills in acquisition of competence left students and employers uncertain of their level of level of technical skill (Runciman *et al* 1999 May *et al* 1997). Subsequently, nursing education re-focused on skill acquisition and technical competence and integrated these more substantially into pre-registration curriculum and assessment strategies to ensure the strong foundation of technical skill that both nurses and patients value.

Dividing technical skill from other skills may be unhelpful for patients who can find it hard to discriminate between them to identify what makes a competent nurse. Patients tended to look for the whole package: 'she has everything' (patient 8). When asked about why it is possible to discriminate one nurse from another one patient said:

*It's very difficult to tell. I would say it's very difficult to tell whether that is competency or whether that's personality.*

*(Patient 16, male, age 26: 79)*

What these extracts highlight is that technical skill is a core element of what patients view as competence in nurses and that patients separate technical and interpersonal skills. However, other reported studies about patients' or relatives' views of nursing indicate that patients focus on interpersonal skills and caring behaviours (Cescutti-Butler and Galvin 2003). The apparent contradiction between these divergent findings can be explained by the discovery of the category: *taking competence for granted*.

## **‘You assume competency is there’ – taking technical competence for granted**

Although patients considered that competence was primarily related to technical skill, when they actually talked about what was important to them, what came across was not nurses’ ability in technical procedures but nurses’ interpersonal and human skills. In contrast to the studies highlighted above, this research indicates that patients would rate technical skill and knowledge to be at least as important as caring attributes in their discussion of the competent nurse. On examination of the data it appears that nurses ‘knowing what they were doing’ was clearly important but patients appeared to have less concern about technical competence, not because it was not important, but because competence in this area was taken for granted. This occurred for two reasons: firstly because this type of knowledge was not considered to be in the realm of understanding of patients, and even expert patients almost always bowed to the superiority of knowledge of the nurse (which will be discussed later in this chapter). Secondly, patients assumed that as a nurse had a position in a hospital he or she must be competent. They trusted that procedures were in place that would only allow competent individuals to be employed in the NHS as the following extracts indicate:

*Oh I think they're really competent. If they werenae competent they wouldnae be in a job.*

*(Patient 10, female, age 78: 44)*

*I mean the whole idea behind nursing situation is you would go through your training, get your qualifications. In theory then you can do the job, which is correct.*

*(Patient 14, male, age 52: 116)*

*Yeah cause you automatically think, well you're the nurse you know. You know, you know, so you don't say anything...em... I would think just cos they have done the have done their training and they have got their qualifications and everything to be a nurse you know...*

*(Patient 27, female, age 29: 130)*

Before nurses reach the level of qualified practitioners who are in the position to care for patients, patients assume that they have been judged by a series of educational and professional judgements. It is these professional judgements which have priority – it is not up to patients to say that nurses are competent in the first instance. This suggests that patients do not only have trust in individual nurses, as described in chapter 6, but also the profession and professional regulation as well.

### **‘I mean who are we to judge’ – The exclusivity of professional judgement**

More significant than the assumption that nurses will be competent because they are in employment is the fact that many patients did not believe that at any time anyone other than another nurse could assess nursing competence. The idea of ‘who are we to judge?’ (Patient 8) came strongly through the data as extracts from two interviews highlight:

*P        Yeah, mainly because I mean you're dealing with so many different abstract concepts. Whether or not they can discuss things with you... Even within diabetic care. I mean the individual is that different from every other individual. I mean what is right for me may not be right for somebody else. And I'm not about to say that I'm the respectable diabetic by any stretch of the imagination. I've got my own problems. Some of them more bigger than others, but you can only take what's given to yourself. I mean if I come up against a nurse who knows what it is they're doing, fair enough. There's probably other factors that are involved as well as opposed to just whether or not they can inject without feeling any, any pain. Whether or not they can make you feel at ease. Whether or not you can make them feel at ease. Whether or not they just handle the applications that they're dealing with. I mean it's one thing to put dressings on but something else completely, to inject somebody. I'm not saying that everybody is cut out for nursing. But at the same time, equally everybody's not cut out to judge whether or not the nurses are competent.*

*LC       And do you think the only people who are cut out to judge the nurses as competent is other nurses?*

*P        Peer pressure, yeah. Peer group.*

*LC       Ok. So you can't see any other kind of group, of patients or anybody else who could judge the competence of nurses?*

*P        Not, not immediately.*

*(Patient 14, male, age 52: 108)*

This issue of the exclusivity of professional judgement in relation to medicine is highlighted by Rosenthal (1995: 27) who indicates that only the profession of medicine can make judgements about incompetence and mistakes. It would then follow that due to the complexities of caring for the patient, only doctors could judge competent care. Judgements over medical care are exclusive to the medical profession as medicine is a self regulating and closed profession. Nursing also has these same issues of self regulation and it is the Nursing and Midwifery Council (NMC) which presides over cases where competence is questioned. The profession itself sets up the standards for competence and education and regulates them in the UK through the NMC. The NMC is supported by statutory bodies such as NHS Education for Scotland (NES) in Scotland.

What competencies nurses were expected to achieve were not clear to patients. One patient talked about not knowing the professional competencies and said she did not know what was involved in the appraisals of nurses and what other nurses would expect, even though she had been attending for renal dialysis for a number of years:

*Well that's the way I see it. But then, you know, I don't know what they've got on their appraisals and what their competence, competencies are. That I don't know. You know that's not something we are familiar with. So I've no idea what they're expected to do. Like you know if a senior nurses was giving them an appraisal what would they expect and what would their objectives be. That I don't know. I don't know what that is...For me to assess it? No. Without knowing what they're expected to achieve you can't really do that.*

*(Patient 18, female, age 51: 90)*

This participant was particularly insightful because she came from a managerial background and was familiar with competence assessment in her workplace, but she expressed something that other patients alluded to: that they did not know what was important for a nurse to know. This was interesting because patients only saw their lack of knowledge about what was important for nursing, rather than seeing what they as patients could judge. This shows that patients did not seem to consider that they had any special or different expertise from nurses or that there may be other aspects of nursing that they would be able to comment on and which could contribute to the assessment of nurses. In the initial interviews patients were asked to comment on the professional definition of competence given by the NMC:

*'...the skills and ability to practise safely and effectively without the need for direct supervision' (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1999 p35).*

All patients agreed with this professional conceptualisation of competence and none offered an alternative view. This supports the view that patients do accept the professional view of competence.

Chapter Five illustrated that patients were confused about the scope of nursing practice which ranged from giving out soup to highly technical procedures. This uncertainty

about the role of nurses on the ward, even from 'expert' patients, does seem to have an impact on the judgement of competence.

Another patient reiterated the view that the lack of professional knowledge that new patients have leads to concern about nurses doing things in slightly different ways:

*Of course you, but you will worry when you're first here, if one nurse does one thing one way and another nurse does it another way, and if you don't know that the consequences aren't really important or negligible, then you may well worry that the nurse is actually doing it wrong you know. Like and a lot of people will sit dumb while people are doing things around their bed you know and if you know, the worry could be that they'll sit and think was it done right or was it done wrong. You know you might not know.*

*(Patient 19, male, age 40: 44)*

Inconsistency in practice made it difficult to identify what was important and could provoke anxiety, if unlike the patient quoted above a patient did not have enough knowledge to realise that doing things in different ways would not have serious implications. The following extracts from interviews highlight that patients do pick up on inconsistent practice:

*But, there's been a number of patients who've been putting it [a drug for renal dialysis] directly into the machine for quite a while now you know. There's been a lot of confusion over what is the actual correct way.*

*(Patient 19, male, age 40: 40)*

*No I don't feel that. It's being dressed and it's being dressed properly. Different nurses. Everybody has different ways of doing things and I accept that. I mean I might do a dressing entirely different from the way they do it. But again, that's all part of the training and I would say the majority it is done basically the same way.*

*(Patient 15, female, age 62: 28)*

*Em, I don't know. It really is hard to you know say, cause they all have their own wee ways of doing things.*

*(Patient 27, female, age 29: 78)*

Although the exclusivity of professional judgement seemed acceptable to patients on the surface they also identified problems with this in practice. This patient suggested that,

although nurses are in the best position to judge other nurses, whether they actually monitor the activities of less experienced staff is not clear:

*But, I really think that the mentors would be the ones who would be in the best position to. But I don't know how much they, how much they walk about with them and how much they monitor it. Because that new little girl was talking to everyone. She was on her own. There was nobody watching what she was doing. So how did they know, you know. So I don't know what their remit is for looking after these new people.*

*(Patient 18, female, age 51: 220)*

Patients talked about feeling safe in the nurses' hands and this suggests that, alongside the exclusivity of professional judgement, the trust that patients have in nurses plays a significant role in patients' difficulties with the assessment of competence:

*I just trust them anyway, because they should know what they are doing anyway, they are in the hospital to do it I just trust them anyway obviously, they will have been through college to be here so they should know something, obviously to see what is wrong with you and that, they have been ok*

*(Patient 3, male, aged 27:144)*

*Now, I understand that you know it's a confidence thing and all the rest of it. But in terms of the majority of nurses, I think yeah there's got to be a degree of trust there, that the care that you're getting is. And I think part of that would be reflected in any type of hospital care I would imagine. There is a trust. There is a trust there that, that what you're getting told. And again, you know, if you're not the sort of person that confronts and you know, shouts down, then, you know, you're relying on that trust to be the case that you know, this is the earliest appointment you can get 9 months time, or let's find the wee bubbles in your machine or whatever. Cause at the end of the day, you know, you would like to think they've got a degree of knowledge about it and with knowledge comes capability I would have thought. But em, I wouldn't know how to judge it either way to be honest, to be honest with you.*

*(Patient 16, male, age 26: 22)*

Trust as a central feature of the encounter is discussed in Chapter Six. Patients use trust as a way of managing uncertainty and not questioning the competence of nurses is used to some extent as a defence mechanism. The exclusivity of professional judgement over nursing competence is one way of supporting this use of trust.



## Seeing the whole picture

The exclusivity of professional judgement has a function in maintaining trust in the nurse-patient relationship but patients also highlighted a number of practical reasons why it was difficult for them to evaluate competence. This centred on not being able to see ‘the whole picture’ and this category has a number of different components. Patients suggested that to judge a nurse on one incident or one skill would not be a valuable judgement of nursing care and suggested that nurses would have to be seen by patients giving care not only in a variety of settings but also over time and in acute and routine care. As has already been identified, patients, even experienced ones, felt that they did not know the whole picture of nursing care, did not know the expected competencies of nurses or could not see all aspects of the nurse’s job in the wider context of care:

*So again there’s appreciation there if you understand the wider context. I don’t think I fully understand the wider context cause I’m not privy to it but I think there is. Whether patients have a full appreciation?*

*(Patient 16, male, age 26: 50)*

*You walk down the corridor, aw this is a no bad ward. You see the nurses, you speak to them but you dinnae ken what’s happened in the nurse’s office 5 minutes ago if something’s went horribly wrong ken what I mean. We don’t see that so we cannae turn round and say aye well this happened and gie the gossip and that cause we don’t know any of it. That’s confidentiality. That’s where that comes into it, do you ken what I mean. So we dinnae get to hear the fuck ups about other patients ken what I mean so.*

*(Patient 25, male, age 21: 120)*

Patients also did not feel that they could see the whole picture of nursing care because nurses often had contact with patients only to undertake a particular task. Although technical competence was assumed, it was in this sphere of competence, the undertaking of procedures, that patients were able to give detailed accounts of what constituted competence, for example in the extract below the patient is able to describe exactly what makes someone competent at taking blood from his perspective:

*Well the way they would like pump the vein up, you know the way they would get the vein like standing out nice and the way they would clean like the surface of the. Aw the wee things, like I mean. And then, like how fast they were daeing it and like if they looked about for the vein instead of just trying to go in straight away and that. And half the times they dae it they're in a rush and they just put in straight away and miss the vein and they're wiggling about inside your arm and that's when it gets sore. That's when your arm gets bruised. But if they would actually sit down and take the time and get the vein pumped up proper and know then actually get in the vein, then it's just that wee scratch through the skin that's. You've got the blood instead of all this hassle of like blood going into the needle of it you know.*

*(Patient 22, male, age 20: 66)*

This patient went on to say that even though he could give a detailed description of competent venepuncture this would not be the whole picture:

*Aye see you wouldnae really be able to see the whole picture. They just came in and that one thing with the blood, know what I mean.*

*(Patient 22, male, age 20: 112)*

Another example of technical care that was described in detail was putting patients on and off dialysis but there was still the feeling that even doing this competently as a one off would not be a good judge of competence:

*You could. I mean the only thing you could say, like if somebody was putting you on and you watched what they did and if you say oh that was fine or it wasn't fine. But I think on a, you couldn't really do it on a one off you know.*

*(Patient 18, female, age 51: 208)*

Seeing nurses over a period of time was highlighted by patients as an important factor to consider when assessing competence. A 'snapshot in time' was not enough to see if a nurse was competent or not:

*You know, if you take a snapshot in time it might be good or bad, you get extremes. But if you take like an average or a ... of whether it's you know, year, 3 weeks, whatever your term is, then you're gonna get as I say, more here or thereabouts as estimates so.*

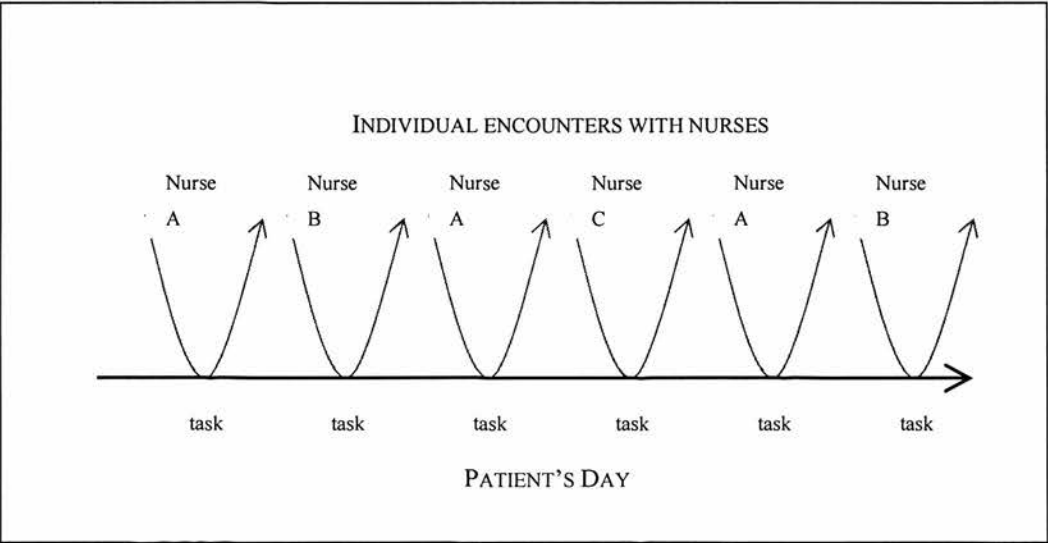
*(Patient 16, male, age 26: 52)*

*I think, I think you have to monitor it over a period of time. I really ... it would be fair to them to do. I mean, you might, somebody who'd just arrived that day or something, you can hardly you know, do it with them you know.*

*(Patient 18, female, age 51: 100)*

This suggests that patients experience transience in nursing care rather than continuity and as a snapshot of one aspect of nursing care rather than the whole picture. This is represented in Figure 1. Individual patients saw themselves as on a continuum at various points along which they have encounters with nurses. These may be with the same nurse or with different nurses and patients may be happy or not with the encounter but they can only see where the encounters bring together the patient and the nurse. All of the other work that nurses do is to some extent invisible to patients. This may include nursing care that is not directly relevant to direct patient care such as paperwork or communicating with other professionals. However, it may also include parts of direct care procedures that patients do not see, for example the disposal of needles after an injection or the complex decision making process that might be the precursor to a particular aspect of care.

FIGURE 1: PATIENT ENCOUNTERS WITH NURSES



Patients whose care was highly routinised, such as the patients having renal dialysis, also indicated that they were not able to see the whole picture of care. Points of contact

between the nurse and patient in these circumstances were planned, predictable and generally involved a technical skill or task. Needing to see nurses out of the routine situation, for example seeing them in a crisis or emergency, would allow patients to determine whether they were competent in a different and more critical situation. Seeing care given in a crisis situation seems for patients to be a good judge of competence. During the interviews a number of patients seemed to value competence in emergency or critical care above routine ward care when they were on the mend:

*I suppose the competency issue is quite a difficult one because it. I don't think I've actually seen them with a sort of crisis situation in here. It's just basically routine, especially on our shift where most people tend to be quite well. You might get a better impression in earlier shifts where much sicker and iller patients are. But in here, the competency issue I, I suppose we don't get to see just how competent the nurses are, really are in here.*

*(Patient 19, male, age 40: 56)*

*No cos usually, by the time I come up here I am sort of on the mend anyway, it is usually in A and E that I am seen to eh? Like I was in resus before I was brought in. By the time I got up here I was sort of on the mend.*

*(Patient 1, female, age 57: 57)*

Continuity of nursing staff was highlighted as an issue that meant that getting the whole picture was difficult. The shift patterns of the nurses meant that a patient only saw a particular nurse at irregular intervals. There was no continuity of care over a period of a few days where the patient would be able to judge competence:

*Yes, yeah. You would. Well to be able to assess the competency of individuals you would have to watch them you know, over a period of time. And when you come in here it's different people every night. You very rarely see the same person 2 days running because they do such different shifts you know so. Like you don't often see. Like I mean [name of nurse] is here tonight. You might not see her again for a week, 2 weeks you know. So I would think that would be very difficult to do, based on the you know. If you were seeing them every day of the week, then yes, I think you would have more chance to do that. But I don't. It's too scattered the way it is at the moment.*

*(Patient 18, female, age 51: 98)*

Twelve hour shifts that were the norm at the research site, because of this the nurses' working patterns may not have them on shift for several days out of a patients' admission. This change in shift pattern from 7 1/2 hour shifts (the same hours but more days in a working month) was expected to give patients greater continuity of care throughout the day. This may well be so but it does not seem to give patient continuity of care between shifts.

## **Nursing care does not have to be perfect**

*Cause I'm sure they've made mistakes. Does competence mean you're perfect?*

*(Patient 25, male, age 21: 242)*

Getting the whole picture and particularly not judging the nurse on one particular incidence led to the development of the category 'nursing care does not have to be perfect'. It was difficult to understand at first why patients would talk about particular incidents of nursing care that were poor but then give a good overall appraisal of the nursing care they received. To patients nurses are primarily human beings and they recognise that humans are fallible:

*... it is just people it is just human [laughs]...human failure you know, so I wouldnae put that down as a fault.*

*(Patient 2, male, age 61: 97)*

*Do you ken what I mean? Does competence make you, mean you're perfect? Because they always say, as the cliché is, nobody in this life's perfect, ken what I mean. So then does that make us all incompetent if we're no perfect, ken what I mean?*

*(Patient 25, male, age 21: 244)*

Nursing care does not have to be perfect to be competent and patients accepted that nurses have to develop their skills. Patients forgave examples of poor care for a number of reasons. One important reason was that nurses were seen as having stressful jobs and that to keep on top of everything was difficult and therefore mistakes were inevitable. Sense of vocation and putting your all into your job were important to patients, but it

seems that this sometimes came at a price. If mistakes were due to overwork, tiredness or stress this was not seen as being a lack of competence:

*They could have just came back from a cardiac arrest where a staff was sitting and she's the one pumping the chest, waiting on the machine coming, but the guy died and she thought. I didnae dae good enough. And then she's still to go and draw up my insulin or something or something like that. She gives me the wrong insulin. I dinnae think. I just put it in and start hypoing major style you know what I mean. I wouldnae say you're incompetent for daeing that.*

*(Patient 25, male, age 21: 76)*

*Yes because there is a danger there it's about life and limb this one it is it is a knife edge here sometimes there must be a thin line you know but I see them checking the drugs all the time it's good but it cannie be easy.*

*(Patient 2, male, age 61: 437)*

It did not necessarily have to be emergency care or busyness of the ward that contributed to nurses making acceptable mistakes. Patients considering 'issues of duty and culpability' (Edwards *et al* 2004; 159) has been identified as a mitigating factor in the assessment of care as unacceptable (Edwards *et al* 2004; Williams *et al* 1998). Within the renal dialysis unit care was highly routinised and the repetitive nature of the job also led to mistakes being made. This repetitive work seemed to make nurses more likely to make mistakes and have difficulty concentrating on their work:

*Because of the certain routine, you know, there are small errors being made on a daily basis you know, which I wouldn't expect from you know, highly competent people you know. But it's obviously a very difficult thing because of the repetitive nature of the job. ...and I'm sure they're all incredibly competent and know exactly what they're doing, but the routine nature of the job means that they don't concentrate as they should, sometimes. But as I said, the newer nurses do.*

*(Patient 19, male, age 40: 146)*

Patients also accepted that nurses have to learn and that sometimes care given by students or nurses new to a clinical area will not be competent. This was acceptable as long as there is a more experienced nurse supervising the care:

*You do get that. You do get that quite often. Em, I don't mind like new nurses coming, put needles in my arm as long as there's a nurse there knows what she's doing. I've had that a few times. You know, I always believe in student doctors and nurses and everything, cause they've got to start from somewhere you know, and I never stop them from doing anything.*

*(Patient 20, female, age 41: 96)*

For patients 'not being perfect' is acceptable but 'not being competent' is not, particularly if a nurse is practising independently:

*I think so. Some of you can tell. They take so long to put you on and off the machines. They take. And a lot of them are sort of a wee bit nervous and em, look for someone else's advice and backup which I suppose is a good thing, but they shouldn't be putting people on and off the machines if they're not ready to and able to.*

*(Patient 21, female, age 28: 112)*

It seems that for patients, care where there are mistakes but which can still be judged as acceptable must have a clear therapeutic intent – nurses have to be doing something for the patient's own good. Patients do sometimes accept poor care if they think there are 'good intentions' behind it, as this next extract illustrates:

*I had this bag [colostomy bag] and everything and there was fluid coming out and blood and everything and one of the she must have been brand new but I felt sorry for her she was an auxiliary eh so she came over and I think that she just wanted to do my pillows or something I can't remember but she sat down on this bag which was covered with the sheet you know...and the thing burst [laughs] oh I said oh god I couldn't believe it and I felt, I felt hate for her because grrr but after I thought what a bloody shame I just think she took shell shock every time she came into the ward she just look over to me and go oh. I hope she got on ok you know because so I must be terrifying for them.*

*(Patient 2, male, age 61: 298)*

This feeling of good intentions can also be applied retrospectively to incidents of care when patients did not feel that they were good at the time but can see that nurses had their best interests at heart. Patients' views of what is good care can change with experience in the hospital setting or changes in health status. What does not seem to change however, are patients' views of bad care.



This second participant was initially unhappy with being forced, as she saw, it to get out of bed when she felt unwell. Again after the event she was about to see why the particular nurse in question ‘forced’ her to get out of bed:

*I mean at times I used to say oh leave me in peace but I know it was for my own good ken for to keep all my lungs ken it’s just at the time I wasnie that well but I am glad they pushed me.*

And later in the interview:

*Well [name of nurse] was a bit thingmie at first but I know thinking back she was only doing it for my sake nobody else which at the time I was sort of quite angry with her I said well I am that ill I cannie... I try to get up and about but when you arnae that well all you want to do is lie in your bed and sleep ken so after that ken I says she was quite alright after it and so was I.*

*(Patient 5, female, aged 57: 181 & 249)*

These incidents suggest that patients’ views of care are not set in stone but are transitory depending on how they are feeling physically and mentally. If patients had been asked at one point in their care how they viewed their care they may well have complained about their treatment. However, the patients at the time of interview were able to reflect on their experiences. This may have some methodological significance for research that examines patients’ views, as one snapshot of care may not be enough to see how patients’ views change and develop.

These extracts contrast sharply with incidents when patient care was not considered to be in the patient’s best interest, as judged by the patient themselves. Some of these instances have been highlighted in Chapter Five.

## **Confidence and competence**

A significant part of judgement about competence is based on the confidence with which nurses give care. Nurses can show confidence through knowledge, being independent in practice, not hesitating, or through asking patients questions about their care. Patients can identify when nurses have confidence:

*Well, as I said earlier, the fact that they just came and knew the machine was all ready and just started doing the things they've got to do. If they were doing it without hesitation and without asking for help or about saying to me. When does heparin come off? They should read it here before they start. Just how long do you do? If they were saying something like that. What's your pump speed? I mean it's all there for them so they shouldn't need to ask an individual patient. So if they were doing all that without having to ask and getting me done without causing bleeding all over the place you know. I think that, I would say that they're pretty competent.*

*(Patient 17, female, age 72: 32)*

*I have every confidence in them they make you feel safe you know cos the are taking...I think it is just the way they treat you, you know and a sort of gut feeling, that's you know. They seem to know what they are doing the one in charge is sort of*

*(Patient 7, female, age 82: 124)*

*well the ones who are qualified are always confident they always look very confident*

*(Patient 2, male, age 61: 82)*

Patients could identify nurses who were more confident and many patients assumed that confidence equalled competence. However, it is important not to take this for granted. One patient indicated nurses can 'bluff their way through it' (Patient 14, male, age 52: 43), that is, appear confident but not know anything, but appearing confident in itself makes patients feel much more at ease with their care. How confidence rated to actual ability to care was not clear:

*Yeah you can sort of judge how confident someone is, but it doesn't mean that they're any better or worse at their job. It's quite hard I suppose.*

*(Patient 21, female, age 28: 118)*

Confidence did seem to be taken by most patients on face value as an indication of ability and led to trust in nurses. Nurses who appeared to be uncertain and had to ask for help, either from other nurses or patients or who became stressed and emotional during busy periods were viewed less positively by patients. Confidence did play some part in gaining an overview impression of the competence of the nurse.

## Expertise – the development of competence over time

*No no, but it's the old story. I think as you gain experience you can tell sometimes with different nurses. Some you realise they've been in nursing for quite a wee while, they've got it all at their fingertips. Some are still learning and they're learning very well and doing the job you know, to the best of their ability. But you feel they're still gaining experience as they're going along. You know, a lot, say there's anything wrong in what they're doing, but you can appreciate they are as I say, still learning ...*

*(Patient 15, female, age 62: 110)*

Patients identified that competence did develop over time and they were able to identify nurses who had experience. This experience was not necessarily borne out in improvement in technical competence:

*You could almost. I suppose, degrees of skill you could. You would still probably have. You see, I mean if I came in here not knowing anybody, then that would take quite a. I mean I know the ones that are the more, probably more skilled if you take it from the point of view of putting somebody on a machine. You could say, well yes she's fine or he's fine. But there's others you might say. Well I'm not so sure about. But, basically a lot of that is down to the fact that they've only been here 2 weeks or they've only been here a month. You're obviously not going to expect them to be able to achieve the same as somebody who's been here 10 years for instance.*

*(Patient 18, female, age 51: 104)*

Expertise that came from experience was seen as inside knowledge that you would have to learn from practice, as this extract below indicates:

*I cannae say. Are we going to take the blood sugar? Right? That's it. There's no hesitation, nothing, of the blood sugar taken. I'm sorry about that, but you know it has to be done. I say oh but I'm quite used to it. I'll put it in the other finger because you'll no feel it the same. You know, things like that.*

*(Patient 10, female, age 78: 60)*

This nurse was able to both use her technical competence and her experience of working with patients: 'I'll put it in the other finger because you'll no feel it the same'. This idea of expert practice is in the professional literature, notably in the work of Benner (Benner 1984), although there are debates about how it can be defined, measured and evaluated

(Bonner and Walker 2004; Edwards 1998; Jasper 1994). Benner and Tanner (1987) highlight some of the features of intuition in expert practice such as similarity recognition, the recognition of resemblances of past and current situations and the development of practice to reflect this, and Hardy *et al* (2002) identify the use of multiple forms of knowledge and self and the intensity of the nurse/patient relationship as features of expertise. These features do resonate with the experience of patients.

Another patient suggested that competence is both learned and earned. It can be learned through training but you also have to ‘come out the other side with the battle wounds’ (Interview 14) to have competence:

*Well I mean competence is learned to a certain degree. Competence is earned as well to a certain degree. Obviously a staff nurse, a ward sister will have more competence because she's been at it longer than somebody who's just come out of training for the first time, who's new at the whole situation. I mean even just going up and chatting to the, to the patients. I mean you can see the difference or if you go up into some of the specialist units, the nurses that have been there for a long time, will have that, that chatter as opposed to maybe the new ones who have to learn how to do that.*

*(Patient 14, male, age 52: 83)*

Patients highlighted the difference between the theory of nursing that can be learned and the practice that comes through working with patients

*My line of work it's 3 weeks. I mean you learn the basic computer skills then you're flung out into the deep end. And it's not until you're flung out into the deep end, that you start to see problems that can arise, how to work around circumstances to bring the cash flow into the office, keep the customers happy, and keep the office administrators happy and that sort of thing. So I mean it's all something that's learned after you come out of training. So I mean I would assume that you can go through 3 years and learn your job, learn it well obviously, cause there's exams at the end of it. But it's not until you start using what you've learned, that then the confidences start coming out. Yeah. I mean obviously if you're out every couple of weeks from classroom to do the practice, that doesn't seem such a great hurdle. But the first couple of times it must be, because your competencies that you're putting into practice don't come necessarily as second nature. That they have to be thought about to begin with. Then they start coming in as second nature.*

*(Patient 14, male, age 52: 91)*

Another patient highlighted the difference between theory and practice in the work situation:

*Well I think that they get much more knowledge I mean there is such a difference between I have always said I always said to my sons when they were growing up and taking exams and that there is such a difference between theory and practice I mean if you put down something on paper and work it out that's terrific but you try to put it into practice no well if we had followed theory we wouldn't be here in the war that had to go out the door we broke every rule there was and just got on with it well we had to otherwise we would never have got there that is the difference between theory and practice I am not blaming people working out things in theory it is a good idea but it has got to be put into practice and see if it will work, because what works on paper does not always work out. I say theory is a good idea but it has got to go into practice before it is used because there is such a difference.*

*(Patient 7, female, age 82: 273)*

So patients can identify that there is not just one level of competence. There is basic competence and competence or 'expertise' that the nurse will develop expertise over time:

*Yes. I mean they will have, knowing how the training works, they will have the basics when they come out onto the wards and they build up on the basics from patient contact and from other, from job contact.*

*(Patient 14, male, age 52: 45)*

This expertise enhances the basic competence which nurses have when they leave education. However this experience and confidence in practice was not always seen as positive by patients:

*I think nurses that have been here for a long time, should know what they're doing. But some of them I think, just forget sometimes you know. I get that impression anyway. For some are just so, the word, how do you say it, so em, sure of themselves that they go a bit too far.*

*(Patient 20, female, age 41: 98)*

This was also highlighted by another patient who felt that working for too long in a highly routinised environment would not necessarily develop expertise:

*I don't really know. I probably go back to the situation of time. I think, well I've often thought that there might well be some nurses in here, right, but don't pass this on. There might be some nurses in here who may well have been here too long. And that's not to say that they shouldn't be in the [name of ward] at certain times. But I would have thought a much better way of being employed within the renal unit as a whole is that you have the renal wards, you also have, I don't think it's intensive care but it's...High dependency unit yeah. And they also have the [name of ward]. I would have thought a sort of rotation around that. Because nurses who work in here, they do get sucked into the routine very quickly. And maybe a couple of years out, then if they were to come back in where things might have slightly changed or different procedures or different ways of doing things, might make them concentrate for a little bit longer. You know, I think there's some nurses in here who have been like setting machines for so long, that they possibly don't even concentrate particularly you know, when they do some things.*

*(Patient 19, male, age 40: 80)*

Confidence and experience then do seem to be aspects of nursing that patients can identify. Patients found it quite easy to identify who was confident, had greater expertise (although not necessarily greater competence) and who they would prefer to give them care. However, as has been seen earlier, this was not necessarily based on the ability to give sound technical care, as patients assumed that this would be present in every nurse. All nurses were seen to be on a similar level as they had been through a course of



education and had employment in the NHS. What seemed to make some nurses stand out was the individual relationship that a patient had with an individual nurse.

## Seeing competence at an individual level

Patients indicated that the individual relationships and the interpersonal relationship that they had with nurses were important factors in the way that they judged nursing care:

*It depends on how, how the nursing staff basically make you feel at ease, which is the crux of the matter.*

*(Patient 14, male, age 52: 43)*

*oh aye yeah cos you you can communicate with them you know... they latch on to that and they act towards that patient how the patient would like to be acted upon I think anyway*

*(Patient 4, male, age 58: 71)*

Patients were keen to stress that they could only judge the care that they alone were receiving, and could not generalise their view of care to situations where nurses worked with other patients. This focus on the individualistic nature of the nursing encounter, the fact that nurses are patient focused and able to meet the individual needs of the patient, was discussed in full in Chapter Six, but its importance and relevance to the assessment of nursing care by patients should be highlighted here.

Patients were focused on themselves and their own needs, and judged nursing care on what they have experienced themselves. Patients felt that they could evaluate nurses on what they knew themselves but would not be happy for this to be generalised, or for it to be assumed that 'if I think this nurse is competent then all patients will think this':

*Em, there's that many different things that you have to evaluate them on. You're not going to know all of them there. We know what they do for us. We can evaluate them on that, but there's other people, different circumstances, different problems that you cannae really evaluate them on.*

*(Patient 24, male, age 23: 131)*



*Yeah and what they want to come and see you for you know. Cause whatever else they do, you know, you don't know, you know. I can only judge them on unless they were to come and see me and do something you know.*

*(Patient 27, female, age 29: 112)*

Assessment by patients in this individual way, as described above, is different to the ways in which nurses are currently assessed in practice situations. Student or novice nurses are mentored or supervised by a registered nurse when learning new skills or techniques. The nurse who is assessing the student is likely to evaluate the nurse with a number of different patients and possibly under different circumstances as they arise, such as in the routine situation or in an emergency situation. The patient can only see their small part of the hospital world and can only judge what they have experienced. It is possible for a nurse assessor to be able to get the whole picture of care, partly because they are privy to professional and contextual knowledge, and partly because they can see the nurse work with a number of different patients who all may have different needs. This transferability of skills and adaptability to the personality and needs of different patients would be seen as part of competence assessment in the practice setting.

In practice, when it related to their own care, patients indicated that they wanted more than technical competence in one skill; they wanted to feel that they were being cared for and they wanted to see that nurses had a vocation and would give their all:

*Yeah I mean the. In [name of other hospital] for example, the technicians put your needles in you know. The nurses administer the drugs and do the professional side of it that way. But em, yeah, like you say, I think there is elements that you don't need nurses. And I think that em, and this is a cruel thing to say, but I think that it is good doing that extra bit and I think it was interesting the way you said competency. What do you expect? Well you expect more. You know what I mean? And it must ... sort if you phone the fire brigade. You want your fire put out you know. You're ill in the hospital, you want the nurse to do ..... you know, and do the extra things. So it is, it is, you know, could be quite demanding I would have thought so.*

*(Patient 16, male, age 26: 98)*

This patient alluded to the fact that in the clinical speciality where he is a patient, the work is so technical that it actually might not need a nurse to do the procedure.

However, it is not just the technical competence that is important. This patient wants to be cared for; he expects more from the nurse than a technician.

## **Assessment of competence by patients**

During the interview patients were asked about how they would view being asked to assess the competence of nursing. Most patients were cautious about how they might contribute to competence assessment as these next extracts illustrate:

*I don't think it would be very easy to assess anybody. It's em, not a thing I've ever done you know. I just say well somebody's doing their job and somehow you just feel somebody's doing that well. And other times you can say, you know, I don't think they're doing that as well as they could do it. (Patient 15, female, age 62: 132)*

*I suppose it would be quite useful, but I don't know how useful. I just, I couldn't do it on a personal. I just couldn't say to someone that they weren't doing something right or. I mean that wouldn't be my place I don't think.*

*(Patient 23, female, age 23: 66)*

Even though the possibility of patients assessing competence was seen as plausible, and even a useful exercise, the majority of patients felt that the reality of actually assessing a nurse would be very difficult. Much of this difficulty came from anxiety about how you would tell someone they were not good at their job:

*Well I dinnae like to say bad things about people. That's the only thing that would put me off. I wouldnae like to say somebody's not competent.*

*(Patient 24, male, age 23: 172)*

*I have aye I would say some are better than other but I won't be the one to judge it is because how would you feel about putting them in a place and I am not here to run them down or doing [incomprehensible] they are doing a good job.*

*(Patient 8, male, age 80: 203)*

*I wouldnie have any thingmie because there is not one of them been any bad ken they have really been quite helpful I just cannie I wouldnie be I wouldnie judge anybody like that ken cos they have been really great*

*(Patient 5, female, aged 57: 213)*

One patient highlighted that patient assessment alone would be a ‘scary’ prospect but could see patient assessment as part of the wider process of competence assessment. He felt that patients would be able to assess nursing as the end users but that patients would not be able to pick up the subtleties of the wider hospital context:

*P No I know that. I don't, I think it would be a useful exercise. I certainly think it should be part of an assessment period cause as I said earlier, patients are the end users. They're the ones that are getting the care and they can you know, best assess if that's what they feel that they need or the priorities that they need. Yeah, so I think it, you know, I would be quite happy to ... towards that. But I think that em, to be the overall assessor might be more scarier prospect I think.*

*LC So you can see it in a context of other people doing the assessment?*

*P I think so. I think there's got to be cause as I say there is other appreciations that need to be taken into account, whether it's staffing levels, whether it's funding levels, whether it's I don't know.*

*(Patient 16, male, age 26: 56)*

This once again reflects the patients' concerns with seeing the whole picture of care and highlights the concern that a patient assessment would not be adequate and that professionals would need to be involved with assessment. This patient above was unusual in feeling that he would be happy to assess competence. Most patients felt that they would find it very hard to tell nurses that they were doing their job well. There are parallels with this in the professional literature. Mentors of student nurses report having difficulty in failing students as this will have serious consequences for the students' career plans (Watson and Harris 1999). The emotional consequences of failing students are described using words such as ‘horrendous’, ‘traumatic’ and ‘draining’ (Duffy 2004:33). Formalising a fail in writing is identified as particularly difficult for clinical assessors (Duffy 2004). ‘Social etiquette’ is the concept that Edwards *et al* (2004) identify to explain what patients decide to say publicly about their care. Patients do not wish to make negative comments about their care as they feel that they still have to have

constructive relationships with health care professionals, and maintaining the relationship was more important than complaining (Edwards *et al* 2004).

#### SUBJECTIVE ASSESSMENT – HAVING A ‘GUT FEELING’

Assessment of competence did not appear to be an objective experience for patients. Patients talked about having a ‘gut feeling’ (Patient 7, female, age 82: 147) about who was and wasn’t competent. This suggests that assessment of competence is not based on the assessment of particular individual aspects of nursing but on a whole impression of the nurse’s knowledge, skills, values and attitudes at an individual level as discussed above:

*I suppose it's just a gut feeling that you have, that you can say, well that girl knows what she's talking about. She's had the experience you know. It comes through, with, well any line of training or whatever line you're in, you can tell whether it's a master plumber or an apprentice sort of style, just to put it quite loosely shall we say. And I think it's the same with nursing.*

*(Patient 15, female, age 62: 118)*

Subjectivity of assessment is also highlighted in the accounts of student nurses as a significant concern (Calman *et al* 2002; Horsburgh 2001; Melia 1997). Students feel they have to ‘fit in’ to the ward environment to get a good assessment. Practice assessors do identify failing students by subjective feelings about ‘lack of interest’ and ‘absence of professional boundaries’ (Duffy 2004: 24) and assessors have to be encouraged to identify clear evidence that students are failing (Duffy 2004).

The next extracts suggest that patient assessment would not only be subjective but would lack validity. As patients cannot see the whole picture they may be assessing nurses on what they feel rather than by an objective and well informed measure.

*You can call anybody competent and you can call anybody incompetent, but that doesnae mean that there's room for that worked ken what I mean. That doesnae mean the shoe fits. Aye, do you ken what I mean? I can judge anything I want to judge, ken what I mean. I can say anything's competent, I can say anything's incompetent. I can say anything's a load of shite. It might be the truth but I can say what I want.*

*(Patient 25, male, age 21: 130)*

*I think the. It's difficult to say, because I think that em. I would say they're probably best placed to do that, but I think whether you'll get an objective patient is another, that understand the environment, the short staffed, the you know, what other things they need to do, bar seeing to this you know, Mr X patient. I don't think you know, whether you can get an objective patient I don't know cause it's a, you know, they can understand, they appreciate the circumstances if you can. So, I don't know. I think that em, they should. Patients would be best placed cause at the end of the day they're the end user. They're the people that get the care, the people. If someone comes into assess or some staff, like in teachers training days and stuff, they all put on their you know, the best class and tell their class they'll all get a mars bar if they smile you know and answer the questions and here are the questions I'm going to ask sort of thing. So at the end of the day, patients must be best placed but I'd, to put a proviso on that that patients can be selfish I would say. So if they're you know, they might. What do I mean by that selfish? I mean that, you know. Well I don't think she's a good nurse because you know. I wait 5 minutes this morning to get my tea and toast. But someone was dying next door but that doesn't matter. You know I didn't get my tea and toast. So you know, that's what I would say to that.*

*(Patient 16, male, age 26: 48)*

This finding is supported by Edwards *et al* (2004) and Williams *et al* (1998), who argue that patients take their experience of health care and transform it even if objective measures of satisfaction or patients' experiences are used for evaluation. Patients are most likely to convert views to a positive evaluation and this results in consistently high reported levels of satisfaction with care (Williams *et al* 1998). A positive outlook on care serves as an important mechanism for patients to face having continual contact with the health care system. Patient evaluation is inherently subjective as it serves another purpose than merely informing professionals of their quality of practice.

## Loyalty

Another category that developed when patients reflected on competence was loyalty. This also complicated assessment of competence for patients. The category relates to the importance of the individual nature of nursing. Central to the quality of the relationship between the nurse and the patient, is the feeling of loyalty patients have to nurses:

*That would be two-faced you know what I mean. I don't think it's true, ken what I mean. I don't think you could say that any of the nurses out there are incompetent. Because for what they've done for me and what I've seen them do for other patients. They go beyond what they're supposed to dae. They put theirselves on the line sometimes ken what I mean.*

*(Patient 25, male, age 21: 162)*

*I have the greatest respect for nurses maybe someone else has a wee grudge about nurses but maybe they have been mollycoddled all their days and they have not had the hardships in life naw aye but eh a lot of patients have high regard for them aye.*

*(Patient 4, male, age 58: 213)*

Some of this loyalty comes from the respect that patients have for nurses and the job they do. This has been examined in previous chapters when patients had an ideal of the nurse as hard working, having vocation, being special people and going the extra mile for them. Patients see nurses as being disempowered in the hospital system and feel a bond with individual nurses who are particularly caring and kind. Patients are prepared to defend nurses to other patients who place unreasonable expectations or demands on them, patients who don't 'know the score'.

## Speaking up about care

Patients do challenge care, but there are a number of qualifications that patients make when it comes to the assessment of the competence of nurse, for example the pressure that nurses are under. As discussed previously patients become more in tune with the context of care and become more understanding and tolerant of care that at first might seem unacceptable to them:



*I think that it possibly could make it easier for some people you know. I mean some people obviously are wanting something right away you know. Maybe somebody needing a commode and someone else is getting attention. They've got to say, Oh I'm sorry so and so. Can you wait a minute or two? And by the time they see to somebody else, well they're running you know, to give somebody else their commode or whatever they're looking for you know. Or even getting a dressing done you know, and sometimes they've got to wait for things coming forward or else they're seeing to somebody else. I mean I've seen this. I'm not complaining. Don't get me wrong. But sometimes they'll say. We'll see about your dressing Mary. I'll say that's alright and it might not be done for another hour or two because they've been caught up with something else you know. And I mean I'm not blaming them, not by any manner of means. It's just they're stretched to the limit and I don't think it's fair to them. You know, they're being put under a lot of strain. That's my personal feeling you know.*

*(Patient 15, female, age 62: 16)*

When this became apparent in the interviews an attempt was made to find out in what circumstances patients made a judgement on care and articulated this to nursing staff. This occurred most frequently in cases where experience of care was negative. There was an occasional comment that suggested that patients would give positive feedback to nurses:

*Well obviously they don't have a lot of confidence but they are trying they are all trying and I always try to give them marks out of 10 you know that is no bad aye [laughs] 6 ½ kid them on a bit because it must be very daunting for them you know...normally they are pretty good I think their training must be quite good must be pretty solid you know because when they come on even to do a wee whatever it is a blood test or something they know exactly what they are doing I think that they are nervous it must be terrible.*

*(Patient 2, male, age 61: 282)*

This patient hoped that his comments would give positive encouragement to nurses who are still developing their skills, but examples of this positive feedback to nurses were uncommon. What was more common was that patients gave instances or potential instances of where they would judge nurses negatively and tell the nurses. This emphasis on the negative suggests poor care was easier to recognise and because it could have serious consequences, patients were prepared to identify it. It was also significant that



most patients seemed to associate assessment with finding the negative rather than the positive in nursing care. There were very virtually no instances, apart from the one above, of patients considering that assessment would be a useful way of providing positive feedback to nurses.

There were instances in their care that patients identified where care was clearly not as good as they had expected it to be. These examples included not replacing a urine bottle at an immobile patient's bedside; forgetting to give a diabetic patient medication before meals and denying patients pain relief. Patients who had been in hospital regularly did get a sense of things going wrong when things happened out of the routine:

*Well... well I always know when there has been a slight hiccup because I know the routines.*

*(Patient 2, male, age 61: 19)*

There seem to be three main reasons why patients in this study who experienced poor care did not feel able to report this poor nursing competence to nurses. Firstly, because they were not empowered to do so, partly because of their confusion at being in a whole new world:

*... I don't know why I just didnae say to them. It's just you're in a strange place and you're in a ... that the system's all different and I just felt well, that wee while's not gonna make that difference. But there was nothing to stop me from telling them.*

*(Patient 10, female, age 78: 30)*

and partly because of the trust that patients had with nurses, assuming that even though something did not seem right the nurses must know better and knew what they are doing:

*P Some of them have no got a clue...havenae got a clue. Well 3 days ago I had, I've got 3 toes that are black and they're gonna well, ... all the time so, right, and the dressings have to be changed each day and [name of nurse] changes the dressings and it's sterile dressing and the gloves and they put the gloves on and they make it a sterile place and all the rest of it. This Australian lassie came up, battered into it and just, nothing, just on top of the bed, on top of the bed....I thought it was shocking.*

*LC Did you say anything to the nurse about it?*

*P No, because that's what she's been showed to do.*

*(Patient 12, male, age 55: 33)*

*LC Why do you not question them?*

*P I don't know, cause you feel that they should be, know that they're doing their job properly.*

*(Patient 21, female, age 28: 79)*

Secondly, patients may be reluctant to report poor care because of the reaction that patients may have from nurses if they complain, as was highlighted in Chapter Five.

*Yeah I did challenge the nurse the other day about whether or not I should inject myself and in the end he did bow to my wishes where he injected me in the arm. But I could see that there was a grudge there.*

*(Patient 14, male, age 52: 29)*

*No you don't complain here. The more you complain then the more that they take things, will take you too seriously. What happens is, is that if you complain too much they get a bit they get a bit nasty. You get the last one to be put on and so. So it's little you complain about things, the best really yeah.*

*(Patient 20, female, age 41: 102)*

This last quote suggests that if patients complained too much the nurses could 'get a bit nasty'. This patient later in the interview went on to explain that it is difficult if patients are in a clinical setting which they have to return to on a regular basis. Due to their condition it is hard to criticise nurses because they have to be able to have a long term relationship with them. This was highlighted by other patients who also had long term relationships with nursing staff, for example those with CF or on renal dialysis:

*Just the way it has to be here. The fact that you have to come, time after time you know.*

*(Patient 20, female, age 41: 116)*

*Cause it's a funny situation [being on dialysis] compared to being in a ward or coming in for an operation. You don't see these people ever again and it's quite unusual I suppose, doing this.*

*(Patient 21, female, age 28: 122)*

These patients' views are similar to the views expressed by student nurses who withheld complaints about other nursing and care staff because they were frightened about repercussions, particularly about getting a 'bad' assessment from their clinical supervisor. Students also felt powerless to influence the care environment so found it easier not to 'rock the boat' (Horsburgh 2001).

Thorne (1993), in her study of the social context of chronic illness, also reports that patients are unlikely to speak up about care, complain or even tell nurses what they want for fear of retaliation. The fact that patients have to go back to the same clinical unit or ward every time they need treatment means they do not see the point in jeopardising care. Why patients thought that care would be affected is not clear but there was a general sense that the nurse would not look favourably at patients complaining. Most patients could give an example of where nurses had retaliated against a patient. Patients also indicated that there was no point in complaining as they had no choice but go back to the same place and be cared for by the same staff again. This is particularly the case for patients in specialist regional or national units. This is supported by Edwards *et al* (2004) who suggest that maintaining a good long term relationship with health care staff is more important than openly evaluating care negatively.

There have been recent media reports that suggest that doctors are reluctant to report instances of poor medical care and an anonymous system of notifying incompetence will be implemented later this year. Even when individuals have professional expertise, which would help them judge care, the perceived consequences for the complainant and the negligent doctor will often prevent the report being made.

It was difficult for patients without expert knowledge to know when something was not going well. They would have to rely on nursing staff to tell them that something had gone wrong unless it was very obvious:

*I mean how could I turn round and say oh that nurse's incompetent because she done this. I don't know what she done, unless it's obvious...it's been an obvious blunder.*

*(Patient 13, male, age 72: 153)*

Even when things do go wrong patients trusted that the nurses know what they were doing. This kind of trust seems to be irrespective of whether patients' knew that something is wrong. Trust here then has a more important function in allowing patients to cope with their situation:

*I think it's quite, I felt that myself that I've actually and I would say that I'm quite vocal. But there has been instances where someone has done a procedure and I wasn't very sure if they were doing it correctly but hadn't said anything. There's, I think we all come in here expecting people to do things right. But you know, there are quite a lot of instances where things aren't done quite correctly you know and.*

*(Patient 19, male, age 40: 46)*

*But I think that em, you know there is certain occasions that em, you know, some nurses, if something goes wrong for example, explain the reason why it goes wrong as opposed to just saying, oh no that's fine. That's your whatever it is. And em, you know, because I've been in a long time you do pick these things up. But I think that em, getting to know you know, if something goes wrong you want to know about it and if you're like me, you're not a sort of character that'll go. NO explain that to me please. No I don't understand. Please tell me. You just sort of sit back and go right, ok. She says I'm fine so I'm fine sort of thing.*

*(Patient 16, male, age 26: 46)*

Patients judged whether they would tell nurses about judgement of their competence by the severity of the mistake. The more serious the consequences of the mistake the more likely that patients would complain. However, given the fact that patients at times cannot recognise when things go wrong, it would have to be obvious to the patient, such as a fall or if the patient is caused pain:

*If there was something really really very badly going wrong, then I would probably say right there's something wrong here.*

*(Patient 10, female, age 78: 26)*

This was reiterated by another patient:

*LC Right. So would that mean that you wouldn't question anything that was happening on the ward?*

*P Unless it was hurting me and I could see it was obviously wrong.*

*(Patient 13, male, age 72: 107)*

An interesting point is that patients having renal dialysis seemed to be more likely to indicate what they would complain about care. This may be because they are more experienced with a technical aspect of nursing care and so are more able to identify when things are going wrong or because the care that they are getting is life saving and potentially very dangerous if something goes wrong. The integrity of the fistula<sup>12</sup> that most patients have, where the needle is inserted for dialysis, is of great importance to patients, as if the fistula 'blows' and stops working this has implications for the future of dialysis. Therefore the insertion of needles by nurses into this fistula for dialysis is a real concern for patients:

*What I've also noticed too, is that, you know, I do my own needles, but some of the nurses are not experienced enough in doing the needles and they cause what's known as a blow in the fistula. Now that can be quite painful you know, if you get a blow in the. It's like the needle goes in the wrong place and it just swells up and it all bruises. It's very, very painful. And I've noticed you know, one or two nurses and then the patients tend to go. I don't want her to come or I don't want him to come. You know they'll do something to me you know. Now that's training. That is definitely down to training.*

*(Patient 18, female, age 51: 26)*

Or when patients see that there are air bubbles in the machine that can have serious implications:

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<sup>12</sup> A fistula is a surgically constructed anastomosis between an artery and vein which redirects blood through the vein causing its enlargement. This enlarged vessel is able to withstand the changing pressures that occur from repeated insertion of dialysis needles (Walsh 2002).

*I mean if there's things, things are obvious I do sort of pipe up and sort of one I'm quite you know, paranoid about, is the sort of bubbles in the system and stuff. And if I'm getting connected up and see a few bubbles I'll say is that ok you know. And they'll say yeah it's not enough to cause a clot or whatever you know, and I'm fine. But I know myself what things to look out for and em...*

*(Patient 16, male, age 26: 24)*

Unlike the category 'nursing care does not have to be perfect' multiple and consistent errors are something that patients would not tolerate:

*But I couldnae base it on one thing. They'd have to be several do you ken what I mean. There'd have to be like 3 or 4, 5 incidents for turn round say. Look, come on eh. She's incompetent man. Get her off the ward.*

*(Patient 25, male, age 21: 74)*

This category gives some indication of what patients will and will not tolerate and at what point patients will speak out, for example, when there are multiple mistakes or when the mistake could have serious implications for their health. When less serious mistakes are made patients have to decide whether it is in their interest or not to discuss this with staff, particularly considering the potential repercussions this could have for their care. The trust and loyalty that patients feel for nurses and the perceived expertise that nurses are considered to have overrides patient expertise on most occasions.

*I mean you cannie say nothing about them because they are there and they are run off their feet some days and when they are there they are run off their feet some days and whenever you are there the buzzers they are there so I mean its nae problem ken I mean you will get a odd yin that will thingmie their face bit five minutes after it its forgotten about ken so I mean I dinnie ken I mean I wouldnie say nothing bad about them*

*(Patient 5, female, aged 57: 259)*

This has implications for patients 'speaking up' about care.

## Consumer behaviour

*And I suppose you know, at the end of the day we're the customer if you want to put it like that. Then we should be getting the best ... service all the time.*

*(Patient 16, male, age 26: 92)*

Patients in this study, contrary to some of the available literature that makes assumptions about patients' willingness to participate in evaluating care (Avis and Bond 1995), were not willing, for the reasons identified above, to evaluate care. This included patients experienced in caring for themselves at home and who were regularly inpatients in the hospital. It is not that they cannot make judgements, it is that they chose not to.

There were some points in the interviews with patients where they did talk about choice and being consumers in the health care system. Some patients suggest that they had a choice:

*You've got to be honest. It's your treatment at the end of the day, ken what I mean. Just cause you're in for treatment you still have the right to refuse it ken what I mean. If there's somebody you don't like.*

*(Patient 25, male, age 21: 80)*

Patients made choices by refusing treatment or waiting for another nurse to come along. These are choices that refuse care which is not so good, rather than making the active choice to go for the best care. This next extract indicates that patients considered that choice is limited, that they had to accept care as 'you are not going to get it anywhere else':

LC      *Right. So even though you sometimes think the care isn't as good as you would maybe expect it to be, you still...*

P        *You've still got to accept it, because you're not going to get it from anywhere else... You're here and that's what you're getting.*

*(Patient 12, male, age 55: 52)*

This patient indicated that the view that the 'customer is always right' is not there in the health service and that nurses carry on and do their work as they have been shown rather than include that patient's view:



*Because the nurse, what is it, the customer. Well the customer used to be always right. Now the customer's seldom wrong. Em, if that's the way the lassie's been showed how to do it then that's how it's done.*

*(Patient 12, male, age 55: 43)*

There were a number of times that patients compared hospital care to a hotel. This however was a way of indicating to other patients they should not be taking advantage of being on the ward and taking their care for granted:

*And there always has been a wee saying going about saying, stop treating the place like a hotel because a few nurses have said that because. I mean, it does happen with some patients have went out and came back at all hours. And some patients have went out and no came back at all until a few days later. You know what I mean? Came back all drunk and that. So, so I mean I think some of us dae like dae that a wee bit, treat it a wee bit like a hotel. So I think we dae push our luck.*

*(Patient 22, male, age 20: 22)*

Another patient compared his hospital stay to being at a five star hotel suggesting that he had experienced a level of customer service that he would have expected to pay for:

*...and the attention you get is like a 5 star hotel...*

*(Patient 4, male, age 58: 107)*

The extract below is from the patient who earlier in this chapter described giving nurses marks out of ten and giving feedback to nurses on their performance:

*...usually only when something goes drastically wrong you begin to question their abilities you know I am quite a good customer any road until something goes wrong.*

*(Patient 2, male, age 61: 390)*

This patient considered himself a good customer, or good patient. He conformed to rules and did not complain until things went drastically wrong. There is the suggestion by this patient that once he starts to complain he then becomes a bad customer in the eyes of the service providers, the nurses, and will have to suffer the consequences.

Patients did make choices about which nurse they want to care for them, by using strategies such as waiting for the preferred nurse to come along. However, patients felt reluctant to voice these choices in the public domain. These choices are often very

limited particularly in a situation where patients have regular admissions over an extended period of time. Choice has become a topical issue for health care with politicians seeing choice as a positive step in the involvement of patients in their care and increasing decision making. However, this has drawn fierce debate about whether patients want to make choices about their health care. Currently choice in health care is limited. The information on the rating of hospital trusts has been considered flawed and difficult for patients to understand (Checkland *et al* 2004) and data on individual doctors and nurses are unavailable.

## Summary

It is clear from the categories discussed in this chapter that participants felt that patients need to have experienced nursing care on more than one occasion to be able to begin to understand both their own role and the role of nurses and to be able to feel comfortable enough with the hospital environment to be able to make judgements of care.

What is particularly important is the development of categories that show that technical competence is the foundation of nursing practice but that this aspect of competence should be judged by nurses. Patients assume that nurses are competent in technical skills and the professional self regulation of competence is enough to reassure patients that this is the case. Technical skill is seen as the domain of nurses and not of patients who surrender to the exclusivity of professional judgement in these aspects of care. Despite this, patients did report making choices when care was not as good as they had expected and when they could identify the potential for a serious negative outcome. Patients acknowledged that they cannot always see or know when things go wrong; this is even when patients have significant experience of managing their own illness at home or have vast experience of a specific treatment in hospital.

Patients acknowledged that nurses can make mistakes and that expertise develops over time but competence is seen fundamentally at the level of the individual relationship between the patient and the nurse. This relationship builds loyalty and trust. Patients

identified that they could not see the 'whole picture' of care and were reluctant to judge a nurse competent on the interactions they alone had with nurses.

This division between technical and knowledge competence and the values and attitudes, the interpersonal aspects of competence, reflects debates in the professional literature about what competence is and how it can be evaluated. Patients did evaluate nursing care and made choices about who they wanted to care for them on this basis but choices were not active: they were to avoid poor care rather than to choose good care. Patients internalised these decisions; they did not want to formalise these or have to deal with the consequences, either for the nurses or for the patient, of formally telling nurses about their care. Not talking about their views of nursing care and informally evaluating nursing did have a purpose for patients. It means that they did not have to consider that care might be poor at times of stress and uncertainty and allowed them to maintain working relationships with nursing staff.

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## CHAPTER 8

### ‘BETWEEN YOU AND ME’ – PERCEPTIONS OF COMPETENCE: PUBLIC AND PRIVATE. A CORE CATEGORY

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#### Introduction

In this study three major categories were discovered from the data that highlighted patients’ views of competence: *knowing the score/becoming a patient*; *recognising good nursing and reflecting on professional competence* (see Chapters Five, Six and Seven). This chapter will report the core category, the main theme that was common to all categories (Glaser 1978). This core category allows the relationship between the three major categories to be explored; it is this relationship that brings meaningful understanding to the concepts developed in this study and which will form a contribution to existing knowledge.

This category, *‘between you and me’*, emphasises both the conceptualisation of competence developed from the unique interaction between an individual patient and nurse and the interpersonal aspects of competence, which were highlighted as significant in patients’ judgements of care. These interpersonal aspects of nursing care were important regardless of a patient’s age, diagnosis or experience as a patient. The development of a list of objective criteria by which nurses can be ‘judged’ was not possible, as competence is not an attribute that a nurse inherently has, it is an impression that patients develop from their individual encounters with nurses. This conceptualisation of competence is something that patients manage privately and only under certain circumstances will patients publicly express evaluations of nursing care.

The properties of the core category highlight the important processes for patients' judgement of competence of nurses and the part these play in explaining the stories of patients. The properties that developed are: *context*; *working together: the interpersonal dimension* and *rationales for private expressions of competence*. A brief description of each property will follow.

Context refers to how the patients perceive the influence of the physical and social context. Working together: the interpersonal dimension, refers to the work of nurses and patients in the nursing encounter. Finally, rationales for private expressions of competence deals with the difficulty of evaluating human skills and the dominance of professional values. These properties are interdependent as views developed through one property will affect views derived from another property, and new meaning is created in their interaction.

## **Context**

The context is both the physical and social context of the hospital ward. As Chapter Five illustrated, patients go through a process of socialisation into the role of the patient. Of particular significance is the role of social control on the ward by both patients and nursing staff. Patients have to learn to adapt to this environment in order to develop relationships with nurses and patients.

The institution plays an important part in the context of perceptions of competence. Patients and hospital staff are influenced by the hospital as an institution. Patients identify that they can only see certain aspects of the institution in their interactions with nurses, but they are aware that the wider institution has an effect on their care. Nurses who can negotiate the different requirements of their roles and responsibilities (Ryan 1997) both to patients and to the institution are valued by patients.

How patients develop their role is complex. Examples of the unwritten rules on the ward indicate how difficult it may be for a patient to understand how to behave. The patient's role is determined by the social system of the institution and is affected by the power relationship between the nurse and the patient. Roles are very difficult to prescribe and

an interactionist perspective may be the most suitable way to understand this. Patient roles change depending on how experienced a patient is and how their negotiation over care is accepted. However, a patient's role as a difficult or unpopular patient may be decided before they arrive in the ward if they belong to a stigmatised group. If this is the case, patients may not have the opportunity to negotiate their role.

Although there is a great deal of the literature concerning the positive aspects of involving patients in health care decisions, the data from this study suggests that traditional views of patients' and nurses' roles are still predominant. These views have been highlighted in seminal literature in the sociology of health and illness. Becker *et al*'s (1961) classic study of medical students found that medical students already had well-formed ideas and expectations about how patients should act and what kinds of people they ought to be, highlighting the importance of professional socialisation in the way professionals view patients, as well as the strength of medical culture. This professional view is still evident in the literature on patients' non-compliance with care and treatment where the nurse is identified as having expert knowledge and it is in the patient's best interests to comply with this (Playle and Keeley 1998; Russell *et al* 2003). When patients do not comply, they are stigmatised as 'recalcitrant, bad, wilful, deviant, recidivist, manipulative, failures, cheats and rule breakers' (Russell *et al* 2003: 283).

There is some consensus of patient roles within the social system and patients try to be 'good' patients as they become socialised into the role. In this study, patients' roles are examined within the constructivist perspective; there are no general rules than can be determined. Patient roles change depending on where they are in their illness trajectory and their experience with inpatient care. Some of the rules suggested in Stockwell's (1972) work do still appear to be evident and some patients are clearly seen as problems to staff, such as the young man with a drug problem in this study. These rules are however not fixed but change throughout a patient's stay, and seem to depend on how a patient interacts with staff. This may explain why patients who are labelled difficult still indicate that standards of nursing care are generally acceptable. One specific incidence

of poor care or strained relationships, although significant to the patient, may not influence a patient's overall evaluation of care.

Observation of nurses' work leads patients to have a confused and generic view of nursing with clarity about good and not so good care seemingly only being evident at the extremes of care, that is, particularly good and particularly bad care. Interview data indicates that experiences of critical incidents at these extremes of care facilitate the understanding of the role of nurses more significantly than everyday experiences. This has consequences for the evaluation of nursing care by patients. The majority of patients will have satisfactory 'everyday' experiences of nursing care as they have difficulty in picking out the role and function of nursing and therefore will find it difficult to criticise or be able to suggest improvement. The data indicates that patients wish to support nurses and try to understand their complex role. This may also make evaluation of nursing care difficult, as it is hard to criticise a profession that is seen to require special attributes and be hard work.

Patients describe that they experience a degree of social control on the ward. At times this is placed on them by nursing staff and other elements of the hospital environment, but it can also come from other patients and even from patients themselves. In general individuals conform to social situations, that is how aspects of society such as hospitals maintain control over a very complex and unpredictable environment.

Social control is derived from expectations of staff and of other patients. The smooth running of the ward depends on this social control. To some extent this social control is given to nurses by patients when they acknowledge their expertise in care, but also nurses demand it because of their position of authority and knowledge. Strong (1979) identified ways in which medical authority was exerted over parents of sick children. Doctors used a number of strategies to take control of consultations, such as writing during consultations and controlling the content and direction of communication. This was of particular note with parents of lower social class and educational attainment. Patients upheld the authority, power and status of the doctor by dressing up in their best clothes for consultations and not bringing up worries in case they looked stupid in front



of the doctor. Doctors did not ask about patients' worries as they did not relate directly to medical care and did not allow the doctor to maintain control over communication. Edwards *et al* (2004) identified that power was found to be implicit in practices and processes of health care which limited the ability of patients to have control over their care.

Nurses are also identified as exerting control over encounters with patients; Menzies (1960) describes how nurses use defences against anxiety, such as depersonalisation and detachment, to maintain control over the caring situation and ensure their own wellbeing. Sinivaara *et al* (2004) highlight circumstances in which nurses exercise power over women. Decisions tended to be made for women who were frightened, quiet or from a different ethnic background and nearly half of staff surveyed said they would make decisions about care on behalf of 'mentally unstable' women. Although nearly all the women in this study indicated that they were encouraged to make decisions about care, 28% thought decisions had been made on their behalf and 19% said they had been persuaded to agree with the staff members' opinions (Sinivaara *et al* 2004).

A significant factor in social control is the limits that nurses place on patients, even though nurses themselves are not always seen as powerful within the wider institution. Social control is maintained through withholding or removing treatment options or through the ways in which nurses communicate with patients. This is most clearly identified in the *problem patients* and *negotiating care* categories in Chapter Five. It is clear that nurses have a powerful influence over patients. The status and power that nurses have is a significant influence when patients are asked to evaluate their care

The work of Foucault (1976, 1979) has been drawn on to examine issues of power in the health setting. Power in Foucault's view exists as a force, independent of individuals and institutions; it comes from interactions where there is an inequity of interests (Porter, 1998). Power relates to both disciplinary power, which was most clearly seen in eighteenth century mental health services, and to power in relation to knowledge of the working of the body that was traditionally firmly in the control of medical men. During the twentieth century the idea of power and surveillance moved from the institutions into

the community. This culminated in the introduction of the National Health Service in the UK, which legitimised surveillance and control throughout all sections of society. Nettleton (1995) suggests that the types of encounter with medical personnel also changed during this time. A greater emphasis was placed on the clinician's function in helping the patient to achieve optimum health, and patients were encouraged to speak about their own experiences of health and illness. Foucault considered that the reason why some forms of knowledge become more prominent than others is because they are enforced by the use of power in relationships (Porter, 1998). However, this power changes depending on the specific interaction. Not all patients are powerless in their relationships with nurses. It is clear from the data that patients do make considered choices about the way they behave and about who they wish to care for them.

Patients have expectations of their hospital experience and these are affected by the circumstances in which they come into hospital, which determine whether their admission is seen as a crisis event or as a break from the responsibility of their illness. Some patients are happy for care to be directed by nursing staff due to uncertainty and acute illness whereas others prefer care to be negotiated. Thompson and Sunol (1995) identify that a primary causal factor for patient satisfaction is the expectations that individuals hold about health services, because 'maximum satisfaction occurs where ideal expectation levels have been reached' (Thompson and Sunol 1995: 134). Patients highlight that their expectations and values change through the process of socialisation into the patient role and expectations seem to become more aligned with the institutional view, such as accepting that they have to wait for care. This development of a more 'realistic' view of care may mean that initial expectations are not necessarily what care is judged by. If expectations change, views of satisfaction may also change.

## **Working together: the interpersonal dimension**

This property emphasises the important work of the nurse and patients and the interpersonal aspect of competence. It is clear from the data that the personal encounters between patients and nurses, when technical competence is assumed, are the most

important part of nursing care for patients. Patients' perceptions of nurses' overall competence are highly influenced by a nurse's caring actions. The importance of personal caring encounters is highlighted extensively in the literature examining patients' views of care (see for example Attree (2001); Halldorsdottir and Hamrin (1997); Milburn *et al* (1995); Fosbinder (1994)).

Care that is needs led, focused on the patient and has the values of care and vocation supporting it is valued by patients. Patients see nurses as people and in turn wish to be seen as people rather than patients. Although patients get glimpses of nurses' interactions with other patients it is primarily on their own experiences of care that they judge nurses.

Caring as a central feature of nursing has been contended by seminal nurse theorists such as Benner (1984), Benner and Wrubel (1989), Leininger (1985) and Watson (1988), but a recent synthesis of research findings on caring in nursing suggests that although caring is theoretically important to many nurse researchers and theorists, patients do not always experience caring when being nursed (Fletcher 1997a). The author suggests that this gap between the theoretical importance of caring for nursing and the difficulties of achieving this in practice may be bridged by the professionalizing of nursing through its integration into higher education (Fletcher 1997b).

There is still some debate as to whether caring should be an essential component of nursing at all. A motion was put forward at this year's RCN congress to debate whether nurses were too clever to care (Royal College of Nursing 2004b). The resolution that the caring component of nursing should be devolved to Health Care Assistants to enable Registered Nurses to concentrate on treatment and technical nursing was rejected (Royal College of Nursing 2004b) but the very fact that this was debated highlights some of the difficulties of the changing role of the nurse. In this study it is clear that focusing on purely technical aspects of patient care may not change patients' satisfaction with the outcomes of care but it will affect their experience of being a patient. Henderson (2000) identified that some nurses felt they were not doing anything for the patients unless they were giving technical care and therefore considered that they were being uncaring. This

focus on the technical and physical becomes a particularly important issue with the development of advanced practice nursing roles.

The development of advanced practice roles worldwide in nursing has led to debate about whether fundamental changes have to be made in the role of the nurse. Although some advanced practice roles enhance the holistic and caring facets of nursing, it is not clear how some of the more technical and medical roles fit into the picture. There is concern that nurses are becoming more task-orientated and taking on roles usually associated with medical staff. This is compounded by the fact that the development of these roles is often determined by medical staff because of the shortage of junior doctors rather than a desire to develop nursing roles around the patient journey. As nurses are taking on roles in areas such as anaesthetics and endoscopy, it is becoming increasingly difficult to draw clear boundaries between the role of a nurse, a doctor or a technician. What is interesting is when nurses take on roles that are traditionally medical roles, such as first contact roles in primary care or clerking in patients in the hospital setting, patients are more satisfied with nursing than medical care (Horrocks *et al* 2002). It is not clear why this is the case. It may be because of a more caring focus, but it may also be to do with how much time nurses spend with patients: doctors and nurses in many studies did not work under the same conditions and nurses could take longer with patients. Another possible explanation is that nurses look at other issues such as social care during a consultation. Further research needs to be undertaken to examine these issues further.

Patients identify caring as part of competence but it is interesting that there is a definite split between technical and interpersonal care, with technical competence firmly in the realm of professional nursing knowledge. Some nurse theorists (for example Watson 1988) have completely divorced caring from technical competence. Haldorsdottir and Hamrin (1997) identify that nurses are involved in professional caring and technical competence is a part of professional caring, and argue that without this technical aspect, care is meaningless. Nurses have to be competent to be considered caring. This supports the findings of this study that technical competence is important to patients. Haldorsdottir and Hamrin (1997) further consider that professional caring almost always

has some action, doing with and for the patient. There is a split in nursing care between the scientific part (which includes communication skills and decision making skills as well as technical skill) and the human caring part, which includes being honest, genuine and involved with, and showing respect to, the patient. Many studies identify caring behaviours and conceptualise them in different ways (reflecting the concerns of clinical areas such as oncology) but few examine how professional caring can be assessed by patients or whether indeed this is possible.

Mackay (1998) suggests that within the modern NHS it is possible to blend the concepts of profession and vocation:

Profession and vocation are not necessarily mutually exclusive perceptions of nursing. It is possible to maintain that it takes a special kind of person to be a nurse, and yet to acknowledge the need for advanced training and skills in nursing.

(Mackay 1998: 67)

Mackay argues that the idea of vocation is still what makes nursing special and nurses entering the profession still adhere to the ideals of nursing as a vocation. However, this is not necessarily borne out in the data presented in this thesis or other research findings and in 2003 there were a number of highly publicised newspaper reports about concerns about the quality of nursing care suggesting that nursing had lost its caring focus.

Caring actions are those that see the patients' perspective on their own health or illness and are seen when patients negotiate with nurses about their care. 'Between you and me' indicates that both patients and nurses have to put work into the relationship. Patients have to invest in their own care whether they are doing this in the traditional patient role as identified by Parsons (Parsons 1951), being the good compliant patient still takes work, or negotiating aspects of work that would traditionally be in the realm of professional care. Patients' work can be implicit (emotional or coping work) or explicit (assisting in setting up equipment), which may be negotiated by nursing staff.

Within the growing body of work on patients' experiences of chronic illness, patients' work has been highlighted as an important concept. Charmaz (1997) highlights the emotional work that patients have to do and this disrupts their sense of self and time.

Strauss and Corbin (1988) identify the work associated with chronic illness. Maintaining the best health involves both health maintenance (which includes monitoring self and adhering to treatment regimes) and emotional work (for example dealing with depression, fear and anxiety). Coming into hospital challenges the control over work that patients have at home. Losing control is reported as being very difficult for patients, and they feel they are 'exhumed into the system', a feeling which is reflected in the category *organisational or system effect on patient care – being on a conveyer belt*, discussed in Chapter 6. The work of Thorne (1993) would suggest that patients with chronic illness experience acute episodes and periods of hospitalisation differently to patients with acute illness. Data reported in this thesis highlights that instances of negotiation and descriptions of patient work came almost exclusively from patients living with a long term condition. Thorne describes how patients with chronic illness relinquish control when admitted to hospital initially because they are too unwell to argue, but soon find dependency distressing. *Negotiating care* (Chapter 5) and *willing dependence* (Chapter 6) highlight the importance of patients actively negotiating involvement in care. Thorne (1993) suggests that nurses are intimidated by patients who 'have been around for a while' so patients have to learn to negotiate care in ways which do not lead to repercussions for them.

Henderson (2000) identified that nurses' attitudes to caring determined their willingness to involve patients in decision making about their care. Not all nurses in this study were able to conceptualise caring in a way that allowed patients to participate in their care. Gallant *et al* (2002) identify that there are a number of antecedents to partnership in the nurse/patient relationship. These include the belief in empowerment, trust and respect and shared responsibility and accountability. It is clear from patients' experiences in this study that some nurses hold these views in particular circumstances, such as the long term care of regular inpatients. The major consequence of partnership is empowerment. However, there is controversy in the literature about whether patients want partnership and empowerment from relationships with health care professionals. The development



of partnerships may place further burden on patients, leading to distress and dissatisfaction with services (Saint Lamont 1999).

## **Rationales for private expressions of competence**

This property highlights the rationales for keeping patient views of nursing competence in the private domain or conversely voicing those views. Rationales play an important role between context and working together. They determine how patients will express their views relating to context and working together, and are fundamental to the potential for public expression of perceptions of competence. Mahon (1996) contends that patients do not always have clear reasons for their evaluation of care, highlighting the difficulty that patients have in expressing their views. It is not a simple assessment of objective criteria, as patients' views are transformed by certain conditions of being a patient in the hospital.

As has been highlighted throughout this thesis, patients do assess the competence of nurses and make limited choices about care for example by engineering situations where they are cared for by the nurses they consider to be the best. As patients do not see technical competence to be in their domain of knowledge, even if they are experienced patients, the 'best' nurses are judged to be those who have the best interpersonal relations with patients. These nurses are kind, caring, show vocation, are patient focused, negotiate care and try to understand what it is like to be a patient. Rosenthal (1995) supports this view and highlights that even though complaints about health care have increased, when patients complain about doctors only a small proportion of those complaints are related to technical competence. Most concern the process of care. Technical competence is not questioned until norms of behaviour are broken.

### **THE DIFFICULTY OF EVALUATING HUMAN SKILLS**

It is possible to see why patients at a fundamental level do not want to assess these kinds of human characteristics in a formal public forum. Although caring is a central feature for the development of patients' views of nursing competence, it is also conversely one



that makes it difficult to evaluate competence: if good care relies on a good relationship, patients are basing assessment on 'human skills', such as being a nice person and being able to form supportive relationships with people. Even when patients have built 'good' relationships with nurses, they seem to find assessing their competence in 'human skills' a step too far, as the assessment of the competent nurse cannot be an objective measure that can be separated from the person. Patients have difficulty separating how they feel about being a patient and about their nursing care. Assessing the values and attitudes of nursing is something that the profession has also had difficulty with, firstly in agreeing on concepts to be evaluated and secondly how these can be evaluated.

Patients experience vulnerability and uncertainty in hospital and thus have a complex relationship with nurses. They must trust them to undertake difficult and intimate tasks and feel loyalty to them as caring and hard working people. This dependency on nursing staff for emotional support and nursing care complicates the assessment of nursing. Some patients in this study were happy to put all of their trust in the hands of nurses. Thorne (1993) describes the three stages of relationships that individuals with chronic illness experience with health care professionals. This model does seem to reflect patients' views as reported in this thesis, that as patients become more experienced their views of trust change. The first stage of this model is *naive trust* – this is exemplified by the passive patient who allows health care professionals to make decisions for him or her; they rely on professionals to know what is best. Patients' expectations are high, trust is absolute and so is confidence in the health care professional. Patients move on from this stage to *disenchantment*, when trust in the health professional is shaken, either by small things over time or by one event that fundamentally shakes confidence. This disenchantment phase may never happen, as trust may be so ingrained into the psyche of the patient that the patient does not question care no matter how poor their experience is.

Guarded alliance is the third stage; patients at this point have a greater understanding of the professional in the larger system and are more willing to take responsibility for relationships with health care providers. Trust is reconstructed but becomes highly selective. It can be defined as trust in the individual rather than in the system. Calnan

and Sanford (2004) support this view and highlight that participants in their survey of public trust with long standing illness are:

sometimes portrayed as “lay experts” and may be more aware of the inadequacies and limitations of health care provision. However, there was no evidence that those with longstanding illness were more likely to report higher levels of distrust.

(Calnan and Sansford 2004: 96)

The conversations with patients reported in earlier chapters of this thesis indicated that patients still have high levels of trust, although perhaps not naive trust, in nurses. Believing and trusting that someone is doing their best for you is important to patients and this is one reason why complaints are not made about mistakes or about nursing care that is not considered as good as it should be. Edwards *et al* (2004) consider that patients have a preference for having a positive outlook about care as questioning the competence of the staff caring for you at a time of crisis and vulnerability does not serve a purpose. This raises an important point for this study of patients’ views of competence. It may be in the interest of professional staff to seek patients’ views but the findings of this study and others (see Edwards *et al* 2004; Williams *et al* 1998) would suggest that it may not be in the interest of patients to have to question the ability of clinical staff.

Another important factor is that patients consider the assessment of nurses’ competence to focus on the negative; only one patient in this study explicitly discussed the value of nurses receiving feedback from patients about their care. The purpose of assessment is not clear to patients and they do not consider that it could be used to give confidence and positive feedback to nurses, failing to see that it could be used to improve practice rather than tell nurses they were not good enough. Patients feel that they cannot tell another *person* that they are not doing a good job. There is a sense of not wanting things to count against the staff. Patients do not want complaints to be formalised, nor do they want to take the responsibility if this has an impact on a nurse’s career.

## DOMINANCE OF PROFESSIONAL VALUES

It has been indicated in this study and elsewhere that the dominance of health care system and unwritten rules of social acceptability, fear of being judged by clinical staff and having little control over all events, lead patients to restrict what they say and do:

There seems to be a perception, justified or not, that failure to adhere to these unwritten rules could result in the withdrawal, or worsening, of some aspect of healthcare provision. (Edwards *et al* 2004: 170)

One of the most important reasons why patients' views of nurses' competence do not move from being private to public is fear of retaliation from nursing staff. Whether this is real or not, as is indicated in the quote above, is not important – what is important is that this is what patients feel will be the outcome. Patients believe this as many have experienced this in their care from nurses or have seen it in the care of other patients, especially patients who fail to comply with care or in some way challenge the authority of nurses.

Patients try to fit into the ward environment in order to maintain good relationship with nurses (Edwards *et al* 2004). This is seen as essential, especially if patients have to maintain a long term relationship with staff, for example, if they have a chronic illness. This idea of patients 'fitting in' to the ward is similar to work on the occupational socialisation of student nurses (Melia 1987). The strength of the influence of nursing culture on the experience of student nurses is evident in the way they adapt to the culture on the ward, despite the theoretical knowledge on patient care they have gained in college or university (Melia 1987; Calman *et al* 2002). 'Fitting in' constituted a large part of student behaviour. Patients, like students, want their experience on the ward to be trouble free. More significantly than this, patients have been identified as accepting responsibility for poor care themselves if something goes wrong rather than blaming nursing staff (Tishelman 1993). This suggests that evaluating nursing care is complex, as patients may only want nurses to know their feelings about care in some situations. Socialisation can cause patients to adopt the traditional views of problem patients internalised by the nursing profession. The functionalist viewpoint of the pre-determined

sick role, with the passive and compliant patient and the knowledgeable and more powerful nurse, still pervades nursing care.

Patients do challenge nursing authority, by asking questions about their care and wanting to be involved in care, but how negative this challenge may seem is dependent on how nurses respond to this challenge. The consequences of a challenge which seems negative to nurses may be costly to the patient. Patients observe other patients being punished for certain behaviours, or experience this themselves. Patients in general behave in the manner that is expected, or wish to be seen as doing so. Patients often become more compliant rather than complain in order to maintain relationships with staff. These factors are important reasons why patients' views of nursing remain in the private domain.

Patients also have concerns about the validity of their claims about nurses' competence. Even when they are experts at managing their own illness at home, patients still defer to the expertise of the nurse in hospital, even when care does not seem to be as patients expected. The idea that nurses know best in most circumstances was pervasive in the data. Patients only considered that an obvious error would be visible to them and most day to day care even if it did differ from the norm for patients, was justified by the fact that nurses must have more knowledge than patients. One possible explanation comes from Thorne *et al* (2000) who indicate that professionals even when they are working with 'expert' patients display behaviours that:

...serve to trigger the kinds of responses within patients that are subsequently interpreted in such a manner as to confirm the professional's disregard for the patient's competence. (Thorne *et al* 2000: 308)

Professionals set up patterns of interaction that reinforce the power relationships between patient and nurse. There were clear examples of this happening in the data reported in this thesis and it was also evident in field notes taken when negotiating access to clinical areas with professionals. During this period, a number of senior managers and ward charge nurses appeared sceptical of the value of patient assessment of clinical competence, frequently making comments such as 'what would patients know?' or 'it all depends on whether they like a nurse.' It seems that for some

professionals the exclusivity of professional judgement is not only valued by patients but also by nurses themselves. Whether patients' views of competence would be taken as legitimate knowledge by ward staff is not a question that can be answered here but would be an interesting line of future work. Ceci (2004) examines legitimate power when examining a case of medical negligence in Canada where nurses' concerns about the work of a surgeon were largely ignored as they were considered to not have any authority of knowledge about medical work. Some of the conclusions could be transferred to patients' authority of knowledge of nursing work, in particular the point that the power of the person making the claim is significant for the legitimacy of the knowledge.

It is not clear whether giving patients specific education on clinical skills or nursing practice would make them feel they had a more valid view of nursing care. It has been suggested that wider access to information leads to a more balanced encounter with health professionals (Zeibland 2004). However it is difficult to say if patients actually want to take a role in the formal assessment of nursing competence. Patients certainly do not consider that their assessment alone would be a complete evaluation of nursing competence and emphasise that they could not evaluate the whole picture of nursing as their views come from their own individual encounters with nursing staff. Choice and increased decision making by patients has become the current trend of policy makers, with the leaders of the government and the opposition both committing to increased choice in the public services. This has stimulated much media discussion. Writing in the Guardian newspaper, a journalist reflects on her views on choice as a person suffering from a chronic health problem (Russell 2004). She makes the point that offering choice to patients highlights that some services are better than others. This introduces uncertainty, which patients do not necessarily want to face at a time of stress and vulnerability. Increasing choice to patients also makes patients responsible for making decisions and forces them to deal with the consequences of making the wrong choice. Asking patients to assess the competence of nurses may also introduce uncertainty and a burden or responsibility to patients that they feel they cannot bear. Russell (2004)

suggests that what she wants from care is ‘great competence and great kindness’ and this is confirmed by patients’ views reported in this study.

## Summary

Patients’ perceptions of nurses’ competence are determined by the three properties of this category. Firstly, the social and physical context of the ward, the inherent power imbalance between nurses and patients and the expectation of the role that patients should fulfil. Secondly, the interpersonal dimension of nursing, which is so important to patients. This aspect, *‘between you and me’*, makes the judgement of competence a very personal experience rather than objective and value free. Thirdly, the rationales for private expressions of competence, which affect whether patients are prepared to bring their views of competence into the public domain or whether they will make passive choices about their care such as avoiding certain nurses or situations rather than face the consequences of publicly disclosing their views. Patients highlighted in Chapter 7 that public expressions of concern about nurses’ competence would only happen if patients’ concerns about their own health outweighed the rationales for keeping views private.

The category *‘Between you and me’ – perceptions of competence: public and private* explains the pervasive theme of the data. Patients focus on the interpersonal aspects of nursing care, as technical competence is assumed. The social and institutional context of the relationship between a nurse and a patient affects patient views. In addition, patients describe a number of rationales that prevent them from vocalising the competence of nurses in a formal or public forum. These findings have implications for the introduction of patient assessment of nursing competence. These implications and conclusions will be discussed in Chapter 9.



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# CHAPTER 9

## CONCLUSIONS AND RECOMMENDATIONS

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### **Introduction**

The aim of this study was to explore patients' views of nurses' competence. The purpose was to gain a theoretical understanding of patients' views of competence in order to inform future development of patient involvement in clinical education. This study has reached this aim by illuminating patients' views of competence. It has identified important theoretical elements that affect patients' judgement of nursing competence.

This final chapter will briefly summarise the main findings of this study and discuss implications for the future planning of patients' involvement in competence assessment. Suggestions for further research in this area will also be made.

### **Study Findings**

The conclusions of this research indicate that the assessment of the competence of nurses by patients is a complex and very personal process. Determining a list of attributes or competencies that patients can judge has not been possible as an outcome of this research. There are some instances in which patients can judge technical competence and can identify broad indicators of competence in other spheres such as communication skills and vocational and professional values. What is clear from conversations with patients about nursing care is that a judgement is made on an individual level; patients did not consider whether a nurse gave competent care to all patients, only whether that nurse gave good care to them as individuals.



Patients also highlighted a number of reasons why their judgments of nursing care remain in the private domain and why public and formal assessment of competence would be difficult. The complexity of assessment of competence can be seen through the properties of the core category: *context; working together: the interpersonal dimension; and rationales for private expressions of competence*. The context of care and the relationship that a patient has with a nurse are two of the many factors which influence patients' views of competence.

Patients divide competence into two domains: technical competence and interpersonal aspects. The development of this finding is a significant contribution of this study. What was also discovered was that patients saw the technical aspects of competence as firmly in the professional realm of knowledge and understanding. The assumption by patients of the exclusivity of professional judgement over technical aspects of care, no matter how experienced the patient, is an important finding. That patients assumed that technical competence exists, as they trusted professional regulation of nurses, should give some reassurance. However, such an assumption places the responsibility on the profession to maintain professional standards and be transparent with the public in order to show them how these standards are being upheld.

When technical competence is taken for granted it is the quality of the interpersonal relationship that patients have with nurses, which has been referred to in this study as the 'between you and me' aspect of care, that patients value the most and that distinguishes certain nurses as being particularly good. This reflects wider views about job performance:

'The key difference between superior and average job performance is not the measurable skills but the soft skills or competencies' (Zhang *et al* 2001: 469)

The profession has battled with the assessment of these human qualities within the framework of competence, and so far has failed to qualify clearly (determine what characteristics these are) or quantify (measure these characteristics in some way) them. It is therefore hardly surprising that patients, even if they could identify these

competencies, suggested that they would struggle to assess these aspects. The situation is made more complex by the fact that patients equated judging the good nurse with judging a good person. This is an individual and personal judgement.

Literature cited throughout this thesis has highlighted unexpected but interesting comparisons in how patients and student nurses see registered nurses' work. It suggests that patients, like student nurses, are not on the inside of care and have to take time to adapt. For similar reasons such as repercussions, loyalty and lack of full understanding of the clinical situation, patients and student nurses do not feel able to speak up about poor care when this is experienced.

The results of this thesis indicate that the assessment of competence by patients may not in fact be desirable for them. To have to question the competence of nurses at a time of vulnerability may be unhelpful for patients. The perceived negative implications for a patients care if they publicly state their views may lead them to be reluctant to express their true views.

## **Reflection on grounded theory as an approach**

Grounded theory provided a helpful approach to this research. The philosophical underpinning of a grounded theory approach is symbolic interactionism (Bulmer 1969). This was seen as a helpful framework for the exploration of the patient experience in the hospital world and the views of nursing care. The foundation of symbolic interactionism is that individuals act towards the environment (both social and physical) in accordance with the meaning or meanings that they hold for them and meanings are developed through interaction with the environment. Individuals are seen as being active in this process assimilating new encounters and new meaning created from them. It could be suggested that this view overemphasises human agency in the creation of meaning and disregards the effects of the institutions and structures in society that affect the agency individuals have. This study has acknowledged the structures and institutions, specifically the hospital, within which interpersonal relationships between nurse and patient necessarily operate.

The flexibility of grounded theory allowed the participants to drive the theoretical direction of the study. The process of theoretical sampling ensured that 'expert informants' were identified to develop the theoretical elements of the study. The constructivist nature of this grounded theory acknowledges that there may be other ways of seeing this data. This is not *the* answer but *a* response to the research question. Another researcher with their own theoretical sensitivity may develop a different emphasis on the theoretical elements in this study. It is hoped that this response will stimulate debate in this research area.

## **Limitations of this study**

Although the aims of this study have been met, limitations are acknowledged. This was a small study which focused exclusively on hospital patients' views of nursing competence. A larger study that would have incorporated patients from other clinical areas would add to the body of knowledge on patients' views of competence.

Patients came from one acute NHS Trust in central Scotland a decision was made early on, at the time of ethical approval and gaining access, that participants would come from this area thus, ruling out patients from community or rehabilitation areas. This could have presented problems for the theoretical sampling however, in the event the acute trust provided enough scope for making choices for theoretical sampling.

Patients were interviewed in the hospital setting rather than at home after discharge, this decision was made to aid recall about the patients experience of nursing care and to determine patients views whilst they were will in hospital.. This could be seen as a limitation as patients, as the findings suggested, were anxious not to upset nurses as this could in their view lead to negative reactions from nursing staff. However, patient responses were rich and detailed about their experience of nursing care and when asked patients did not want to be interviewed at home and that their views expressed would not have changed even if they had been interviewed at home.

Whilst caution must be exercised in generalising the specific findings from this study, patients' views of competence highlighted in this thesis would be relevant in practice

and education and add one perspective to the debate of patients assessment of nurses competence.

## **Implications of this study**

Implications of this study can be identified for policy, practice and education.

### **IMPLICATIONS FOR POLICY**

If patients trust the exclusivity of professional judgement and therefore take technical competence for granted then there have to be ways for the profession to evaluate competence that will ensure the trust of the public. One way of doing this is to develop a national system of competence assessment, with the freedom for some local development, so patients know what the level of competence should be and how it is assessed. It should be some reassurance to the leaders of the nursing profession that patients do trust that the system of self regulation is enough to take technical competence for granted, even though evidence suggests that current systems of the assessment of student nurses are allowing failing students through the system (Duffy 2004; Watson and Harris 1999).

Involvement of users in the evaluation of health care is a significant aspect of health service policy. There have recently been moves away from using large scale surveys of patient satisfaction to a focus on quality of patient experience using patients' stories and narratives to convey to clinicians the quality of experience. Notably the NHS Modernisation Agency has embraced this method of seeking patients' experiences of care through the Discovery Interview Programme (Wilcock *et al* 2003; NHS Modernisation Agency 2004). The findings of this study would support that move. This would allow patients' views to be contextualised and allow patients' voices to be heard in the way in which they want rather than in the context that health professionals want to hear it in.

Current developments such as the expert patient project (Department of Health 2001b) may impact on patients' views of service. In this project newly diagnosed patients are put in touch with 'expert' patients who have a role in educating and supporting their peers. This development of and recognition of patients' expertise may help to redress some of the issues of power so clearly seen in the data reported here.

## IMPLICATIONS FOR PRACTICE

This study highlights a number of implications for nursing practice. This study strengthens the growing knowledge base of how patients see nurses and nursing care and there are valuable lessons in what patients say. Some of the patients' vivid and articulate descriptions of incidents describe unacceptable behaviour from nurses. What should be of more concern to senior clinicians is that patients, because of the way that their views are transformed by mitigating issues, are unlikely to disclose these incidents, preferring to indicate that their care is acceptable. This is partly because of the influence of mitigating issues on patients' views and also because of the repercussions that patients fear, both for themselves and the nurses involved. Lastly, it is because it is not in the patient's self interest to acknowledge that care is not of an acceptable standard.

The data highlights that much of what patients appreciated in their nursing care, when technical competence was assumed, were the small things that indicated that nurses saw things from the patients' perspective. Patients valued patient focused and needs led care by nurses who could express a sense of vocation. How this is achieved within the busy ward environment, when the nurse must manage competing priorities from the institution and patient, is not a question that can be answered from the findings of this research and further work should be undertaken in this area.

## RECOMMENDATIONS FOR EDUCATION

Patients valued the exclusivity of professional judgement of technical skill. This suggests that educational providers must be transparent in how students are assessed and inform the public of how professional standards can be guaranteed through courses of

education. This does not mean that patients have to be involved in this process; in fact patients highlighted the limitations of this development. Patient evaluation of student learning does not answer the problems associated with the competence based approach to education and there may be more useful ways of incorporating patients' views of nursing care into the curriculum

Educationalists should proceed with caution with patient assessment of nursing competence. The rationales for patients' views to be public or private highlight the complexity of how patients come to decisions about competence and whether to voice those decisions. Accounts and measurement of competence through the use of rating scales or other objective measures will not necessarily uncover private views of competence. It is difficult to quantify the complex individual relationship which is key to the development of the perception of competence for patients. This study has revealed that patients find it hard to talk about nursing without talking about how it is to be a patient. A method of assessment that allows patients to put their views of competence in this context is important.

## FUTURE RESEARCH

A number of interesting questions arise from this study and it would be valuable to continue to examine these in the light of current developments in the UK of patient assessment of practice placements.

Patients' views of nursing competence highlight many of the debates in the professional literature about the assessment of competence. Further research must return to examining competence assessment and clarifying the related concepts. Without clear professional definitions of competence it will not be possible to involve patients in the process as there will be no clarity of what should be assessed and how. Multi method approaches to competence assessment seem to be the most helpful way forward but no gold standard has been developed, perhaps with the exception of the OSCE. This is of

particular importance with the development of advanced practice roles and the blurring of boundaries between the professions.

Further research should also include an examination of whether patients want to be involved in the assessment of competence. At the moment the drive is coming from the professions which consider that patients' views on care are a 'good thing' and would increase the validity of assessment. There has to be a clear understanding of the patient agenda, of what patients would gain from assessing practitioners. The data presented here suggests that it is not clear whether patients wish to take on this role which may in fact be counterproductive to their well-being at a time of vulnerability. Involvement in assessment is a decision that patients will make at an individual level and will be likely to change on each admission.

Examining specifically how patients' views move from private to public and how this could be facilitated would be a potential development from this study. This would increase understanding of how patients come to decisions about the quality of nursing care.

It would be also interesting to undertake a similar study looking at patients' views of other health care professionals, for example doctors or physiotherapists, and examine whether the same theoretical elements are present. It may be that different members of the health care team need different types of evaluation from patients because of the context of their relationships.

Further work as to how the use of qualitative methods can inform health care professionals about their practice needs to be undertaken. This could be a useful way forward in the involvement of patients in assessing their care. The discovery interview project (Department of Health 2004) has gone some way in developing this method. It uses whole interviews, rather than analysis of a number of interviews, to get a clinical team to look at patients' experiences and improve service. This allows the context of the



patient's experience to be integral to evaluation of service. Further investigation of this method and evaluation of whether this actually changes practice needs to be undertaken.

Finally, an investigation of the use of patient interviews, in a similar method to discovery interviews, in clinical education may prove to be useful in identifying an alternative to an objective style of patient assessment of competence. This would allow patients to give feedback in their own words, and with the context intact, on their experience of care. Methodological work on the evaluation of change after this process would also have to be undertaken.

## CONTRIBUTION TO KNOWLEDGE

This thesis contributes to existing knowledge in a number of ways. It identifies how patients define competence as technical and interpersonal. It also highlights that patients consider technical competence to be the business of professionals and not patients. Finally, it examines the complexity of the development of patients' views and the transformation of these views into public or private assessments of competence. This last aspect is particularly significant.

This study helps create an understanding of the conflicting evidence about what patients value in their care. Literature on the subject has either advocated interpersonal *or* technical skill, with the notable exception of Halldorsdottir and Hamrin (1997). This study indicates that both are important and that technical skill is the foundation of competent practice, but that patients do not discuss this because it is seen as in the domain of nurses and not patients and it is assumed to be present.

This thesis adds to literature that highlights that simplistic notions of patients' views of care such as questionnaire or satisfaction surveys do not take into consideration the complex negotiation that patients have between a number of different factors.

## SUMMARY AND CONCLUSION

The findings from this study highlight a number of key debates in the field of competence assessment. Firstly, it reemphasises the difficulty of definition of competence. Patients highlight that competence from their perspective relates to both technical aspects of nursing care and interpersonal attributes. Within the professional literature it is clear that there is a debate as to whether competence includes care or care includes competence. The move towards the measurement of competence using objective means suggests that the health care professions focus on the more easily definable and measurable aspects of competence leaving the attributes most important to patients ill defined and unassessed.

This continued debate and lack of consensus over the definition of competence would make some of the recommendations from this study difficult to implement. If a national instrument for the assessment of competence was to be considered then an agreement would have to be reached about definition, teaching, learning and assessment strategies. In the UK there is a professional definition of competence and competencies have been identified for entry to the professional register (Nursing and Midwifery Council 2002; United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1999). However, there is no agreed strategy regarding how these competencies may be assessed and it is clear that some students are currently slipping through the net of assessment. (Duffy 2004).

If methods of competence assessment are so difficult to agree upon then maybe the profession should question the focus on competence as a means of ensuring that nurses are fit for practice. It is possible that the breaking down of nursing into discrete parts, competencies, has actually given the profession a more complex job in assessment, not an easier one, as quality of care is a reflection how all of these competences are integrated and not just a sum of the parts.

This thesis goes some way in illuminating patients' views of competence; it highlights that patients view competence as dichotomous, divided into technical care and

interpersonal care. Patients do assess competence but these evaluations are used to inform private choices about care. Patients identify rationales for their concern about the disclosure of their views to nurses. It is the interpersonal care that makes an individual encounter with a nurse stand out more from another. This is an interesting finding at a time when nurses are taking on more and more technical care and have been accused of neglecting the more personal elements of care.

Implications for practice, policy and education have been identified and how this research may be developed discussed. Although patients' assessment of nursing competence has begun to be implemented in the UK, the issues around this need to be further clarified, particularly the issue of whether it is in the patients' interest to be involved in assessment.

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# APPENDIX 1

INITIAL INTERVIEW TOPIC GUIDE AND TOPIC GUIDE PHASE  
TWO

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## Initial Interview topic guide

An open question will be used initially to allow the participant to discuss their nursing care from their perspective.

“Tell me about your nursing care while you have been in hospital?”

To clarify discussion probes such as those below may be used depending on how the discussion develops;

Can you give me an example of particularly good nursing care that you received?

Can you give me an example where you thought the nursing care was not as good as you thought it could have been?

What was the most important thing that nurses did for you whilst you were in hospital?

Can you tell me what you understand by competent nursing practice?

*(This could be prompted by asking about competence in other professions e.g. plumber)*

Are there any particular competencies that you think nurses should have?

Do you think that patients can judge the competence of nurses?

### **The Professional View – to be introduced later in the interview**

The nursing profession has defined competence as

‘...the skills and ability to practise safely and effectively without the need for direct supervision’ (Peach 2000 p35).

What do you think about this?



## Interview Topic Guide – phase two

An open question will be used initially to allow the participant to discuss their nursing care from their perspective.

“Tell me about your nursing care while you have been in hospital?”

To clarify discussion and develop initial categories:

What is it like to be managing your condition at home and then coming into hospital?

As an expert/experienced patient how have you found your nursing care?

Can you tell me what you understand by competent nursing practice?

- is caring part of competence or is it primarily about technical skill?

Is competence/competent a word you would use when thinking/talking about your nursing care?

Some patients have told me that being cared for as an individual is important to them – what do you think about this?

Can you give me an example of competent nursing care that you received?

Can you give me an example where you thought the nursing care was not as competent as you thought it could have been?

*Probes (if relevant)*

Even if you have experienced care which was not as good as you expected why do you still consider nursing care to be good?

Have you discussed with the nurses that your care has not been good? If not, why not?

What was the most important thing that nurses did for you whilst you were in hospital

Do you think that patients can judge the competence of nurses?

Dialysis patients:

Is it possible when experiencing a technical procedure regularly to determine differences in ability of the nurses?

What are these differences?

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## APPENDIX 2

INFORMATION SHEET FOR PATIENTS AND CONSENT FORM

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26 April, 2001

DEPARTMENT of NURSING STUDIES  
The University of Edinburgh  
2nd Floor  
12 Buccleuch Place  
Edinburgh EH8 9LW

Tel. 0131 650 4272  
Fax. 0131 650 3891

lynn.calman@ed.ac.uk

### **A study of patients' views of nurses' clinical competence**

I would like to invite you to participate in the above study and would appreciate you taking some time to read this information sheet.

#### **What is the study about?**

Much is known about what nurse's view as competence in practice, but what is not clear is how patients view competent nursing. This study will examine patients' views of competence in nursing practice. The intention is that this will improve the care received by patients by giving nurses a greater understanding of patients' views of care.

#### **What will I be asked to do?**

If you agree to participate in the study, I will arrange a convenient time for me to meet with you in hospital shortly before your discharge or at home (or in another mutually convenient place) shortly after your discharge. The meeting will last for approximately 1 hour. During this meeting I will ask you some questions about your nursing care. This interview will be audio (tape) recorded. You will only be interviewed once. You will have the right to withdraw from the study at any time. *This will not alter the care that you would normally receive.*

#### **How was I selected for the study?**

The medical and nursing staff on your ward identified you as someone who might be eligible to take part in this study.

**Confidentiality**

Your hospital consultant and GP (family doctor) will be made aware that you are participating in the study. Any personal information discussed with the researcher at the interview will be treated in the strictest confidence. No one will be able to identify you from any report published about this research. No information you give will be passed on to any doctors or nurses caring for you.

**The researcher**

I am a qualified nurse currently undertaking a post-graduate degree (PhD) in the Department of Nursing Studies at Edinburgh University. If you wish to ask me any questions before we meet, you are welcome to telephone me on 0131650 4272.

**Independent advice**

You may wish to ask the advice from someone who is not involved in the study. If so, You can contact Ms Juliet MacArthur, Practice Development Facilitator, Western General Hospital, Crewe Road EH4 2XU. Telephone: 0131 537 1276. Please feel free to discuss this with a member of your family or a friend if you feel you need more advice.

**Thank you for taking the time to read this information.**

Lynn Calman, Researcher

University of Edinburgh, Telephone: 0131 650 4272

26 April, 2001

DEPARTMENT *of* NURSING STUDIES  
The University of Edinburgh  
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12 Buccleuch Place  
Edinburgh EH8 9LW  
Tel. 0131 650 3899  
Fax. 0131 650 3891  
lynn.calman@ed.ac.uk

***TITLE OF STUDY***

A study of patients' views of nurses' clinical competence

***NAME OF INVESTIGATOR***

Lynn Calman  
Department of Nursing Studies  
University of Edinburgh  
2nd floor, 12 Buccleuch Place,  
Edinburgh, EH8 9LW  
Telephone: 0131 650 3899

***FURTHER INFORMATION FROM***

Ms Juliet MacArthur  
Practice Development Facilitator  
Western General Hospital  
Crewe Road EH4 2XU  
Telephone: 0131 537 1276

- **I agree to participate in this study**
- **I have read this consent form and the participant information sheet and have had the opportunity to ask questions about them**
- **I agree for my hospital consultant and general practitioner (family doctor) to be informed about my participation in this study**
- **I understand that I am under no obligation to take part in this study and that a decision not to participate will not alter the care that I would normally receive**
- **I understand that I have the right to withdraw from this study at any stage**
- **I understand that this is research from which I cannot expect necessarily to derive any benefit**

***NAME OF PARTICIPANT .....***

***SIGNATURE OF PARTICIPANT AND DATE.....***

***SIGNATURE OF INVESTIGATOR AND DATE .....***

3 copies of this form to be made: Top copy to be retained by the researcher  
Second copy to be retained by participant  
Third copy to be sent to participants hospital consultant

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## APPENDIX 3

### PERSONAL INFORMATION QUESTIONNAIRE

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## Personal Information

**Date of Birth :**               /        /       

**Age** :

**Sex** : Male [ ] Female [ ]

**Ethnic Origin :**      Bangladeshi    ☐   Black African      ☐   Black Caribbean    ☐  
                                  Black other    ☐   Chinese              ☐   Indian                   ☐  
                                  Pakistani      ☐   Asian other        ☐   White                   ☐

Other \_\_\_\_\_

**Marital Status :**      Married   [   ]                      Single   [   ]

<b>Highest Educational Qualification :</b>	School Leaver	[ ]
	O' Grades (or equivalent)	[ ]
	H' Grades (or equivalent)	[ ]
	Professional Qualification	[ ]
	Degree or Diploma	[ ]
	Higher Degree	[ ]

**Currently Employment:**    Unemployed    [ ]  
    Employed        [ ]

Occupation \_\_\_\_\_

Full time      [   ]  
Part time      [   ]

**What type of accommodation do you live in :** Purchased home [ ]  
 Rented (council) [ ]  
 Rented (private) [ ]  
 Residential care/nursing home [ ]  
 Hostel/temporary accommodation [ ]  
 Other \_\_\_\_\_



**About your hospital admission :**

Diabetes

Asthma

Renal

How long have you had this condition?

Why are you in hospital this time?

How long have you been in hospital for?

No. of previous admissions for this condition?

Have you been in hospital before for any other reason?

**Consultant Name**

**GP Address**

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## APPENDIX 4

ACCESS LETTERS TO CLINICAL MANAGERS AND LEAD  
CONSULTANTS AND INFORMATION SHEET

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23 April, 2001

Clinical Manager

\*\*

\*\*

\*\*

DEPARTMENT *of* NURSING STUDIES

The University of Edinburgh

2nd Floor

12 Buccleuch Place

Edinburgh EH8 9LW

Tel. 0131 650 4272

Fax. 0131 650 3891

lynn.calman@ed.ac.uk

Dear

Research Project: An investigation of patients' views of nurses' clinical competence

I am a postgraduate student in the Department of Nursing Studies at the University of Edinburgh. The study I am proposing to undertake for my doctoral studies will focus on patients' views of nurses' competence. Although the professional views about nursing competence are well documented in the literature there is virtually no empirical research that clarifies the nature of nurses' competence from the patient's perspective.

The National Health Service (NHS) plan published in England in July 2000 clearly states that 'patients are the most important people in the health service'. However, patients often do not feel listened to. The NHS Plan and Our National Health published in Scotland indicate that patients should have more influence over their care and the way in which the NHS works. The new pre-registration nursing curriculum shifts attention to 'competencies' as the outcome of nurse education and, in an era when patients' views are increasingly seen as important, their views on 'nursing competency' are important to investigate.

I have the support of Director of Nursing and Practice Development Facilitator to undertake this study at the \*\* Hospital. The Local Research Ethics Committee has approved the study. I have approval from Trust management via the Research and Development Office.

In brief, the study will be based on interviews (approximately 48) with in-patients in medical, surgical and orthopaedic clinical areas in \*\* NHS Trust to determine their views of competence. Interviews will last approximately one hour. Initially interviews will be undertaken either at home soon after discharge or in the hospital pre-discharge to determine which setting patients are most comfortable discussing their nursing care in. Whether patients are interviewed at home or in hospital, I would like my first

contact with them to be in the wards. Suitable participants will be identified by discussion with medical and nursing staff on the wards. Prior to the commencement of the study I would meet with the ward nurses and doctors and have information dissemination meetings to raise awareness of the project. I hope to commence interviews in May and will continue data collection until December.

There are obvious practical considerations for undertaking this research and I would be grateful for the opportunity to meet you and the Charge Nurses from the identified wards to discuss the possibility of interviewing patients. The wards I have identified as suitable for the research that are under your management are identified on the attached sheet. This sheet also identifies managers in the trust that I am contacting and the other clinical areas involved.

Please do not hesitate to contact me if you wish further information on the above project. I look forward to hearing from you.

Yours Sincerely

Lynn Calman  
Nurse Researcher

30 July 2002

Dr \*\*  
Lead Consultant  
\*\*\*

DEPARTMENT *of* NURSING STUDIES  
The University of Edinburgh  
2nd Floor  
12 Buccleuch Place  
Edinburgh EH8 9LW

Tel. 0131 650 3899  
Fax. 0131 650 3891

lynn.calman@ed.ac.uk

Dear \*\*\*

**Research Project: An investigation of patients' views of nurses'  
clinical competence**

I am writing to request your support for the continuation of the above research project. I would be grateful if you could, after discussion with the multidisciplinary team, confirm if you are willing to give your consent for the undertaking of the next phase of data collection in ward \*\*\* Hospital.

I am a postgraduate student in the Department of Nursing Studies at the University of Edinburgh. The study I am undertaking for my doctoral studies focuses on patients' views of nurses' competence. I am writing to ask for your agreement for a small number of your patients to participate in this study.

Professional views about nursing competence are well documented in the literature; however, there is little empirical research that clarifies the nature of nurses' competence from the patient's perspective. The National Health Service (NHS) plan published in England in July 2000 clearly states that 'patients are the most important people in the health service'. The NHS Plan and Our National Health published in Scotland indicate that patients should have more influence over their care and the way in which the NHS works, however, patients often do not feel their views are recognised. The new pre-registration nursing curriculum shifts attention to 'competencies' as the outcome of nurse education and, in an era when patients' views are increasingly seen as important, their views on 'nursing competency' are important to investigate.

In brief, the study is qualitative in approach, using Grounded Theory method and is based on interviews with in-patients in medical and surgical clinical areas in the \*\*\* NHS Trust. The study sample will be approximately twenty patients, ten have already been interviewed, and therefore the number of participants from your ward area will be small. Interviews will last approximately forty minutes. Previous interviews have been undertaken with participants who have been admitted to hospital with an acute

illness and it is now important to interview patients with chronic health problems and who have regular contact with hospital nursing staff to compare their views.

Suitable participants will be identified by discussion with nursing and medical staff on the ward and will be patients experienced at managing their renal condition at home. Inclusion will be based on each individual's ability to give informed consent, I would therefore not anticipate that acutely ill, distressed or confused patients would be eligible to participate, please see attached sheet for further details of inclusion and exclusion criteria.

I have agreement in principle from the Charge Nurse \*\* and have written to the Assistant Operational Manager \*\* to request utilising the \*\* ward as one of the research sites. The Local Research Ethics Committee has approved the study and I have approval from Trust management, the Medical Director and the Director of Nursing, and the Research and Development Office (see enclosed letters). I would like to secure your support for the ongoing data collection, which I would like to start as soon as possible.

I have enclosed an information sheet that gives some further details of the study. If you wish to discuss this research further please do not hesitate to get in touch. I have enclosed an addressed envelope for use in the internal mail for your convenience.

I look forward to hearing from you.

Yours Sincerely

Lynn Calman  
Postgraduate Student

*Enclosed*

Information sheet

Copies of ethical review certificates from LREC and LUHNT

Copies of consent form and patient information sheet

29 July 2002

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### **A study of patients' views of nurses' clinical competence**

Over the next few weeks I would like to invite a small number of patients from Ward \*\* at \*\* Hospital to participate in the above study and would appreciate you taking some time to read this information sheet.

#### **What is the study about?**

Much is known about what nurses' view as competence in practice, but what is not clear is how patients view competent nursing care. This study will examine patients' views of competence in nursing practice.

#### **What will the participant be asked to do?**

Once written informed consent is obtained, the patients will be asked to participate in a face-to-face interview. This will take place either in hospital before discharge or at home (or in another mutually convenient place) shortly after discharge. The audio-recorded interview will last for approximately 40 minutes, during which the participant will be asked questions about their nursing care. The participants will be asked specifically about their experience of being admitted to hospital when they are experienced at managing their condition at home. This interview will only take place at one time point. It will be emphasised that participants will have the right to withdraw from the study at any time and that participation will not alter the care that they would normally receive.

#### **How will the participant be selected for the study?**

The clinical staff on the ward will identify patients who are eligible to take part in this study. The criteria for this are: study participants will be inpatients in the designated clinical area at the time of recruitment to the study, they will have been an inpatient for at least three days, so they have sufficient experience of nursing care to participate in the interview, and will be experienced at managing their asthma or cystic fibrosis at home.

Patients who are not judged able to give informed consent by ward nursing and medical staff, who are unable to express their views due to communication difficulties, who are involved in other intensive research studies or are unwilling to participate, will be excluded from this research.

*Please turn over*



**Confidentiality**

Any personal information discussed with the researcher at the interview will be treated in the strictest confidence. Participants will be assured that no one will be able to identify them in any report published about this research and no information will be passed on to doctors or nurses caring for them.

Participants will be aware that their hospital consultant knows that this study is taking place and that they may be invited to take part in it (a copy of the consent form will be placed in their hospital notes) and that their GP will be informed of their consent to the study.

**The researcher**

I am a registered nurse currently undertaking a post-graduate degree (PhD) in the Department of Nursing Studies at Edinburgh University. If you wish to ask me any questions about this study you are welcome to telephone me on 0131 650 3899 or contact me at The Department of Nursing Studies University of Edinburgh, 2nd Floor 12 Buccleuch Place, Edinburgh EH8 9LW or email [lynn.calman@ed.ac.uk](mailto:lynn.calman@ed.ac.uk).

**Independent advice**

The participant may wish to ask the advice from someone who is not involved in the study. If so, they can contact

\*\*\*

**Thank you for taking the time to read this information. Please get in touch if you wish to have any further information about the study.**

Lynn Calman  
Postgraduate student  
University of Edinburgh  
Telephone: 0131 650 3899

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# APPENDIX 5

## GLOSSARY OF BROAD SCOTS TERMS

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# BROAD SCOTS – TRANSLATION OF LANGUAGE/TERMS USED BY PARTICIPANTS.

ane -	own	no -	not
arnie -	are not	no gonna -	not going to
aye -	yes	och -	term of frustration
biddy -	old lady	oot -	out
cannie -	cannot, can't	sair heid -	sore head
crabit -	bad tempered	spewing -	vomiting
dae -	do	tae -	to
dinnae -	don't, didn't	the gither -	together
doesnae -	does not	thingmie -	general term for anything when you are unsure of the correct word, can be an object or person
doon -	down	wee -	small, little
frae -	from	wernae -	were not
gie -	give	wouldnae -	would not
gieing -	giving		
gonna -	going to		
greetin' -	crying		
hadnae -	had not		
havenae -	have not		
hen -	slang for another person usually, female		
wasnie -	was not		
ken -	to know		
mair -	more		
maist -	most		
naeboddy -	nobody		
'nipping your heid' -	complaint when someone is annoying you		